

PSYCHOTHERAPEUTIC MOMENTS

**Putting the
Words to Music**



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Psychotherapeutic Moments:

Putting the Words to Music

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Dedication to My Dad **December 20, 1912 – February 17, 2011**

When I was in medical school, I had a dear friend whose father died unexpectedly, leaving my friend totally unprepared to deal with the pain of her grief about his sudden death and filled with regret about all those things she had never told him and all those conversations they had never had in his “living years.”

And so began my tradition with Mom and Dad: Every year at Christmas, upon my return to Bethesda from Boston, as soon as Mom and Dad had picked me up at the airport, I would ask them, rather boldly, I know, if they were ready to die! Bless their souls that they were willing to indulge me in this way! So Mom and Dad would tell me that they weren't quite yet ready to die – but we would then go on to do a wonderful year-in-review – all three of us stepping back from the moment to reflect upon our lives, the choices we had made during the previous year, our hopes for the upcoming year, and where we felt we were along the path of our life. And every year we would end these conversations with a reaffirmation of our love for one another, just to be on the safe side, because you never knew, for sure, when that year might be the last. As it happens, this very special tradition continued for 36 years with Mom, 45 with Dad. Having this amazing opportunity to know that both Mom and Dad were giving life their very best and were deeply grateful for

how their lives were unfolding did, indeed, make it a little easier for me when their time finally came.

Even so, Dad, I do miss you terribly – your gentleness, your sweetness, your kindness, your humility, your playfulness, your loving heart, your dazzling brilliance, your cleverness, your precision, that sparkly twinkle in your eye, that amused smile, that wonderful chuckle of yours. Your wry sense of humor and your quick-wittedness. Your love of Ogy (our family’s summer cottage in Western New York) and those years you spent there as a child; your excitement about trains and train schedules; your cherished collection of atlases; your passion for music (something that you and Susan shared); the pleasure you got from playing the piano and practicing the pieces over and over again until you got them just right; the delight you felt in doing your Prizewinner contests every month; the tremendous joy you derived from playing chess (you, a decorated Chess Master) and from playing bridge (you and Doug, both Life Masters, the highest level of bridge achievement). And I know how proud you were of your years at Harvard and of being on the Harvard Chess Team that beat out Yale four years running. And how much you and Mom loved the Cedar Lane Unitarian Church, you the Head Usher for all those years.

I remember with such delight how you and Mom loved watching Masterpiece Theatre together. And every evening before dinner, you and

Mom would have your Happy Hour with a glass of wine and game after game of Scrabble (and, later, Upwords) for which you kept a running tally, Mom the high scorer in the early years, you the high scorer in the later years, and a tie by the end. And I just loved it that you and Mom had your nightly ritual of reading to each other before bed. It made me feel so safe, grounded, and secure in the world and that all was well.

Dad, I loved you so much. And I loved it that we had the very same initials – MCS. You were such a gentle, dear man – with such a sweet disposition and generous soul.

I loved that game we would play with those five Chinese vases on the windowsill at the top of the stairs. We were constantly sneaking up the steps to rearrange them when we thought the other one wasn't looking. It was such a sweet connection that we shared.

When I was in high school, I would be talking on the phone with one of my girlfriends – and you would be in the next room, working away on your contests. Whenever my friend and I would start talking about boys, I would lower my voice and whisper to my friend: "I have to talk quietly so that Dad won't hear!" At which point you would pipe up from the next room: "I'm not listening!"

I so loved just being with you, Dad, and relaxing with you, like all those

times when I would ride with you in the car to Safeway or the A&P. A special treat was going out with you to the mailbox, which couldn't have been more than ten yards from our front door. But, whenever you were going out to get the daily mail and I was home from Boston, you would call upstairs to let me know, so that even if I were in my pajamas, I could quickly dress, rush downstairs, and head out with you to get the mail. Our little ritual filled me with such joy.

For me then, as now, some of the best moments in life are those lived in the spaces between.

One beautiful spring morning there suddenly appeared a little bunny in our front yard. Dad and I watched as it tentatively approached the front steps of our house, hesitated for a quivering expectant moment, and then suddenly darted out of sight. In fact, almost every morning that spring, the little bunny would come to visit, usually about 9:30. Although we never knew for sure, Dad and I had a strong suspicion that it was this very same expectant-but-hesitant little bunny who was visiting us every spring. So Dad kept a daily log in which he carefully tracked when the little bunny had come (that day would score a "1") and when the little bunny had not come (that day would score a "0"). And every month, whenever I was away, Dad would send the sheets to me so that I too could know when our little friend had come to visit and when he hadn't. To this day, I have those daily logs.

Gunnar and I have a summer home on the ocean in a fairly secluded area in Marion, Massachusetts. Our house is at the very end of the street. At one point, Dad asked me: "If Gunnar were to be out of town and you got sick, then what would you do?" To which I responded: "Well, we do have neighbors on one side of us." To which Dad, with a twinkle in his eye, responded: "But what if you got sick on the other side?"

Some years ago, Dad and I were visiting Doug in Pittsburgh. We had accompanied him to the Annual Barbecue run by the Tennis Club of which Doug was President. One of Doug's tennis friends came up to the three of us, and introductions were made. His friend then turned to me and said: "Your brother is such a good tennis player. Martha, do you also play tennis?" To which I responded: "No, sadly, I don't. I only play badminton." At which point Dad, without a moment's hesitation, piped up and said: "Well, maybe you could play bad-tennis!"

A few Decembers ago, I was trying to complete my 50,000 miles for the year so that as a Frequent Flyer on American Airlines, I would be able to renew my Platinum Status. My plan was to take an overnight round-trip flight between Boston, Massachusetts, and Portland, Oregon, by way of Dallas, Texas, that intermediate stop in Dallas enabling me to secure the additional 6,350 miles that I would need to bring my grand total for the year to over 50,000 miles. The entire trip could be done between 3 pm Saturday and 11

am Sunday. I knew that Dad would appreciate my strategy, so I told him about my plan. Without skipping a beat, Dad challenged: “But suppose the pilot decides to take a shortcut!”

During their later years, when Mom and Dad lived at the Charter House in Silver Spring, it was important to Dad that every Tuesday, come rain or shine, he be perched at his station on the Spring Street bridge over the railroad tracks (several blocks from the Charter House) so that he would be able to “greet” the daily 4:12 pm Capitol Limited train as it approached the bridge. And so, for years, every single Tuesday, at 4:12 pm sharp, there Dad would be, stationed expectantly at his post on the bridge. In the early months, as the train approached the bridge, Dad would wave excitedly but nothing would happen. There came a time, however, when his persistence paid off and the engineer of the train began to acknowledge his presence with a little toot of the horn as the train approached the bridge, much to Dad’s delight!

But one day, Dad, per his usual, waved excitedly as the train approached the bridge – but there was no toot. Devastated, he went back the next Tuesday, positioned himself at his usual spot on the bridge, and waved excitedly as the train approached but, again, no toot. And the next several Tuesdays, but no toot. Not to be deterred, Dad decided to try a Wednesday at 4:12 pm – but there was no welcoming toot. Thursday – no toot. Friday, Saturday, Sunday – no toot. Heavy of heart, Dad finally tried a Monday.

So there he was, at 4:12 pm, at his station on the bridge. He waved excitedly as the train approached, at which point he was greeted with a heartwarming crescendo of “Toot! Toot! Toot! Toot! Toot!” Dad and the engineer of the train had reconnected, to the delight of both, and so began Dad’s “new routine” – to the bridge to wave to the train and his friend the engineer every Monday at 4:12 pm.

But after Mom died in 2001, Dad fell into a depression with which he struggled for the rest of his life. He missed Mom terribly, and, without her, he didn’t quite know what to do with himself. He ached with loneliness.

A few months later, I was visiting Dad at the Charter House. He had moved into a smaller apartment in the same building, an 11th floor apartment with a lovely view from his balcony. We were relaxing together in his living room, both of us, quite frankly, rather depressed and missing Mom.

I could see that the door to his balcony was blocked by a stack of his papers on the floor. So I asked him: “Do you ever go out onto the balcony?” He said: “No.” I asked: “Why not?” He said: “Well, I guess I’m afraid that I might jump so I keep the papers there to block my access to the balcony.” That seemed like a reasonable enough explanation to me, so I said: “Oh, OK.”

Then he asked me: “But would you like to go out onto the balcony?” And I said: “No.” He asked: “Why not?” I said: “Well, I guess I’m afraid that I might

jump!" Dad paused and then said: "Well, maybe we could make a pact and then both of us go out onto the balcony at the same time!" I thought about that for a moment and then asked: "But which-a-way would we want the pact to go? Would we be agreeing that neither of us would jump or that both of us would jump?" We looked at each other and suddenly burst out laughing, both of us comforted by the knowledge that neither one of us was alone.

Mom and Susan always loved poetry and, as I have matured, I too have come to appreciate it.

A lovely, well-known 1936 poem by Mary Stevenson, entitled "*Footprints in the Sand*," captures beautifully, for me, the way in which Dad and I "held" each other.

One night I had a dream –
I dreamt that I was walking along the beach with the Lord.

Across the sky flashed scenes from my life.
For each scene I noticed two sets of footprints in the sand –
one belonging to me and the other to the Lord.

When the last scene of my life flashed before me,
I looked back at the footprints in the sand.

And noticed that many times along the path of my life,
there had been only one set of footprints.

I also noticed that this had happened
at the very lowest and saddest times in my life.

This really bothered me, and I questioned the Lord about it:

“Lord, you said that once I decided to follow you,
you would walk with me all the way.
But I notice that during the most troubled times in my life,
there was only one set of footprints.
I don’t understand why, when I needed you the most,
you would have left me.”

The Lord replied: “My precious child,
I love you and I would never leave you.
During your times of trial and suffering,
when you saw only one set of footprints,
it was then that I was carrying you.”

Dad and I talked a lot about death and how one could prepare for it. It comforted us both, I guess, to name it, to anticipate it, to plan for it.

At one point, I said to Dad: “Well, you’re not dead yet!” To which he responded with a wry smile: “Well, not entirely.”

Of his roommate at Country Meadows in Pittsburgh, where he spent his last years, Dad said: “My roommate is a zero.” After a short pause, however, he added: “But then he probably thinks I’m a zero!”

I asked him one day: “Dad, where do you think you’ll go when you die?” To which he somewhat unexpectedly responded: “Well, I don’t know, but I’m not all that crazy about the United States!”

As Dad got near the end, he told me: "I'm getting ready to go. I just hope that I can go quietly and painlessly."

Over the last few years, he and I had had a number of conversations about how he might ultimately choose to die. At one point, he had said to me: "Martha, you're a doctor. How would I do it?" I had said: "Well, you would need to keep drinking water in order to keep yourself hydrated but then you would basically stop eating." Dad had replied: "So if I decided to die by starving myself to death, when would I start?" To which I had replied: "You would start when you stopped." To which he had replied: "Well, could I stop once I started?" To which I had replied: "Oh, yes, you could stop once you started and then start again once you stopped!" To which Dad had replied: "Well, I'm glad we got that clarified."

Shortly thereafter, Dad, having just turned 98, decided that indeed his time had come and so he stopped eating. It was his choice. At the time of his death, he weighed no more than 90 pounds. The doctors said that he died of nothing in particular but I know that Dad died of a broken heart. Amazingly, when he died, he had no medical diagnoses and was on no medication. He died in peace, surrounded by love. He died with dignity. He was in no pain. He was ready to go. And so it is that he let himself slip away quietly and painlessly into the night. I'm sure that he has joined Mom and his sister, Nancy, whom he adored.

The Chinese Ring Puzzle was one of Dad's and my favorite pastimes – 86 steps to remove the seven interlocking metal rings from the horizontal metal loop; 86 steps in reverse order to get them back on. Dad and I played this game for over 50 years. All I knew how to do was to take the rings off; all Dad knew how to do was to put them back on. And so, for more than half a century, we handed that puzzle back and forth to each other, sometimes many times over the course of a day. We never tired of it.

Whenever I would come home from Boston, the little puzzle, all assembled, would be up in my room, waiting for me. I would immediately take the rings off and hand the puzzle to Dad, who would then put them back on and hand the puzzle to me. Back and forth, back and forth the entire time that I was at home!

The very last thing that I would do before returning to Boston would be to take the rings off the loop and hide the puzzle somewhere for Dad to find once I was gone. But I was always secure in the knowledge that it would be put back together again by the next time I saw him.

But, Dad, now that you're gone, there's no one anymore to put the puzzle back together for me.

I miss you so much, Dad – all the ways in which you “held” me and took care of me. Without you, the world is a lonelier place now. It's like there's a

hole in it, where you used to be.

The author of the following quote is unknown but it really resonates for me: “There are things that we don’t want to happen, but we have to accept; things that we don’t want to know, but we have to learn; and people whom we can’t live without, but we have to let go.”

In closing, to you, Dad, I say as I used to say when you were alive: “I don’t know for sure where we go when we die although I, too, hope that it won’t be somewhere in the United States, but, wherever you and Mom have gone, know that when my time comes, I will look forward to joining you there... All my love, For Always and Forever....”

To you, Dad, with whom I had so many special moments of connection, I dedicate *Psychotherapeutic Moments: Putting the Words to Music*.

Introduction

Ordinarily, what transpires in the therapist's office is a very private matter and not for public viewing. It is a sacred space that affords patient and therapist the opportunity to *find* each other and, over time, to develop mutually satisfying ways to work, love, and play together. If all goes well, both will ultimately deliver the best of who they are, the worst of who they are, and the most of who they are into the room. There will be rupture and repair, uncertainty and clarity, collapse and recovery, all of which patterns are part of the dance that will unfold as patient and therapist negotiate the ups and downs of their intimate, deeply personal connectedness. Only in this way can there be real engagement and moments of authentic meeting between them.

Psychotherapeutic Moments: Putting the Words to Music arose out of my desire to offer the reader a glimpse of some of what takes place in the office of a psychoanalyst who, although trained in the tradition of maintaining neutrality and striving always to keep the countertransference at bay, has evolved over the course of the decades into a much wiser, much more accessible, much more generous, and, ultimately, much more humane participant in the ongoing healing process and watershed moments that will inevitably transpire when two people deliver themselves, heart and soul, into the intimate space between them.

My interest has long been in the interface between theoretical constructs and the clinical situation. By offering the reader both a conceptual framework and numerous extended clinical vignettes that speak to the direct application of theory to practice, this book represents my effort to put my money where my mouth is. My goal throughout is to bring the psychotherapeutic process alive by highlighting the ways in which psychotherapists can position themselves in relation to their patients so that the therapeutic potential of each moment can be optimized.

Although not always easy to capture in words the magic that can unfold between two people, in the chapters that follow I have done my very best.

Chapter 1 – Relentless Hope: The Refusal to Grieve highlights the importance of confronting – and grieving – the reality that no matter how desperately the patient might want to be able to make the object of her desire over into who she would want it to be, she might never be able to make that actually happen. Her refusal to deal with the pain of her grief about the object’s refusal to be possessed or controlled will then fuel the relentlessness of her pursuit of it – both the relentlessness of her hope, to which she clings as a defense against grieving, and the relentlessness of the outrage she experiences in those moments of dawning recognition that the object can be neither possessed nor controlled and that she is not going to get, after all, what she had so desperately wanted and felt she needed to have in order to

go on.

Chapter 2 – On the Capacity to Experience the Self as “Good Enough” highlights the importance of confronting – and grieving – the reality of our own, very real, limitations, which will enable us to transform our sense of ourselves as a failure into humble acceptance of the reality that, under the circumstances, we are being and doing the very best that we can. As a complement to Winnicott’s (1965) concept of the *good enough mother*, I have therefore developed the concept of the *good enough self*, a concept that speaks to the capacity to experience the self as not always perfect, as often making mistakes, and as certainly limited in many ways – but as basically good enough. Central to this concept is the idea of being able to forgive oneself again and again for sometimes being a disappointment.

Chapter 3 – Acceptance, Forgiveness, and the Capacity to Relent is my story and speaks to how I came to understand, from a place deep within and in relation to my mom, that the capacity to relent is ultimately a story about acceptance and forgiveness.

Chapter 4 – Introjective Identification: Taking on Another’s Experience as One’s Own develops the concept of introjective identification as a counterpoint to projective identification. Both relational dynamics involve detoxification of the patient’s unmanageable states, but whereas projective

identification involves the patient's exerting of pressure on the therapist to take on, as the therapist's own, the patient's unmanageable internal experience, introjective identification, I suggest, involves the therapist's initiation of the therapeutic action by entering into the patient's experience and taking on the patient's unmanageable experience as her, the therapist's, own.

We therapists are so lucky to be able to do the work that we do. Thank you so much for your interest – and, whether you are patient and/or therapist, I hope you will enjoy what follows!

Acknowledgments

I wish to offer my heartfelt gratitude to all my patients, colleagues, students, supervisees, and friends who have helped me, along the way, to go ever deeper into my own process. In particular, I owe a debt of gratitude to Christine Amis, Kathleen Bielawski, Patty Bresky, Gayle Buff, Donna Cameron, Andrea Celenza, Jolyn Davidson, Steve Dudley, Jamie Levin Edwards, Ken Emonds, George Fishman, Michelle Gast, Gail Hartman, Larry Hedges, Sheryl Knopf, Claire Levine, Gail Libman, Larry Lifson, Elizabeth McGuire, Rick Miller, Pat Ogden, Ellen Parker, Al Pessa, William Rea, Lin Reicher, Amy Reiss, Adam Rosen, Robert Royston, Sylvia Rubin, Laurie Scheck, Judy Silverstein, Pat Smith, Mark Steinberg, Bessel van der Kolk, Rory Wadlin, Rick Warner, Joni Wernick, and Kristen White.

From the bottom of my soul, I thank Jay Aronson for his unwavering belief in me and in my ability to put this book together once I was good and ready to!

Finally, without my dear, sweet Gunnar by my side every step of the way, I could never have done this. For decades now, he has truly been the wind beneath my wings. Thank you, my love.

Chapter 1 – Relentless Hope: The Refusal to Grieve

“Pretending that it can be when it can’t is how people break their heart.”

– Elvin Semrad (Rako and Mazer 1980)

Relentless Hope as a Defense

Relentless hope is a defense to which the patient clings in order not to have to feel the pain of her disappointment in the object, the hope ultimately a defense against grieving.

The patient’s refusal to deal with the pain of her grief about the object, be it the infantile, a contemporary, or the transference object, fuels the relentlessness with which she pursues it – both the relentlessness of her hope that she might yet be able to make the object over into what she would want it to be and the relentlessness of the outrage she experiences in those moments of dawning recognition that, despite her best efforts and her most fervent desire, she might never actually be able to make that happen.

Inability to Sit With the Pain of One’s Disappointment and Grief

To review: What fuels the patient’s relentlessness (both her relentless hope and her relentless outrage) is her inability to sit with the pain of her

disappointment in the object, an object she experiences as bad by virtue of the fact that it is not now, nor will it ever be, all that she would have wanted it to be.

The Object Can Be Neither Possessed nor Controlled

But even more fundamentally, what fuels the relentlessness of the patient's pursuit is the fact of the object's existence as separate from hers, as outside the sphere of her omnipotence, and as therefore unable to be either possessed or controlled. In truth, it is this very immutability of the object – the fact that the object cannot be forced to change – that provides the propulsive fuel for the patient's relentless pursuit.

Paradoxically, such patients are never relentless in their pursuit of good objects. Rather, their relentless pursuit is of the bad object. In other words, it is never enough that the patient simply find a new good object to compensate for how bad the old object had been. Rather, the compelling need becomes first to create or, more accurately, to re-create the old bad object (the comfort of the familial and therefore familiar) and then to pressure, manipulate, prod, force, coerce this old bad object to change.

A popular song that speaks directly to this issue of the patient's need to re-create the early-on traumatic failure situation is a rock song by the late Warren Zevon (2007) entitled "If You Won't Leave Me I'll Find Someone Who

Will.” The patient can re-find the old bad object in any one of three ways: (1) she can choose a good object and then experience it as bad (projection), (2) she can choose a good object and then exert pressure on it to become bad (projective identification), or (3) she can simply choose a bad object to begin with!

Again, choosing a good object is not a viable option; a good object just does not satisfy. Rather, the need, fueled by the patient’s repetition compulsion, is to re-encounter the old bad object and then to compel this bad object to become good. It is this, and only this, that truly fulfills the long-frustrated infantile need to possess and control the bad (immutable) object.

By way of brief example: A woman who has suffered terribly at the hands of an alcoholic parent will not simply resolve to choose a partner who does not drink. Rather, she will find herself unwittingly drawn to men who are alcoholic. She will proceed to focus her relentless efforts first on forcing them to own the fact of their alcoholism and then on forcing them to give it up, although they may well never do this and a panel of 10,000 objective judges would probably have been able to predict this.

Too Painful vs. More Manageably Painful

Point of clarification: We are here speaking to situations in which the patient’s experience of disappointment is simply too painful to be borne –

intolerably painful, more disappointing than can be processed and, ultimately, adapted to. Rather, the pain of her grief cannot be fully processed and must, instead, be defended against.

The patient's refusal to deal with the pain of her grief fuels the relentlessness with which she pursues the object, both the relentlessness of her entitled sense that something is her due and the relentlessness of her outrage in the face of its being denied. Hoping against hope, she pursues the object of her desire with a vengeance, refusing to take no for an answer, insistent that the answer be yes.

Winnicott and Fairbairn

I hypothesize that had the relentless patient (as a very young child) had the experience, at least for a while, of having her every need recognized and responded to by a parent who could have allowed herself to be possessed and controlled, by a parent who could have allowed herself to be shaped by her child's evolving relational needs, by a parent who could have allowed herself to be found as a good (mutable) object, then the patient would now, as an adult, have a much greater capacity to tolerate the separateness of her objects and a much less urgent need to pursue them relentlessly in an effort to make them over into the good (responsive) parent she should have had early on but never did.

The “Good Enough” Mother’s Ability to Respond to Her Infant’s Need to Possess Her

It is to Winnicott that we owe our understanding of, and appreciation for, the very young child’s healthy need to possess and control her objects, an age-appropriate need that the mother must, at least initially, be able to gratify if the child is ever to move successfully beyond this early stage in her development. Says Winnicott, a mother who is good enough will be so exquisitely attuned to her infant’s every gesture that the mother will be able, again and again, to meet the omnipotence of her infant, thereby reinforcing its sense of personal agency. Then, as the young child, in response to an inborn maturational thrust and facilitated by the experience of a good holding environment, begins gradually to abrogate her need for omnipotent control of her objects, she will transform the infantile need to possess and control (and, when thwarted, the infantile need to destroy) into the mature capacity to derive pleasure from controlling not her objects but her own life (Winnicott 1965).

The Mother Who Cannot Allow Herself to Be Shaped by Her Infant’s Need

A mother who is not good enough, however, will be unable to satisfy her infant’s developmental need to have complete and absolute control of her surrounds, unable to recognize and respond to her infant’s needs, demanding instead that the infant recognize and respond to her own. As a result, the child

will never outgrow her need to be the center of someone's world; rather, as she grows older, the child will be unable, and unwilling, to relinquish her illusions of omnipotent control over her objects. The thwarted need will become defensively reinforced over time and ever more charged, ultimately manifesting as a relentless drive to possess and control the objects in her world and, when the fact of her objects' separateness and immutability confronts her with the limits to her imagined omnipotence, an equally relentless drive on her part to retaliate by attempting to destroy them.

Feelings of Helplessness Resulting From Thwarted Desire

In fact, when a patient complains bitterly of feeling helpless, generally what underlies that feeling will be a wish to be able to force the object of her desire to change in some way. In other words, a patient's plaintive cries of helplessness often speak simply to the outraged frustration she is experiencing at being confronted with the limits of her power to control another.

Fairbairn's Ambivalent Attachment to the Bad Object

As I will soon be developing in greater detail, it is to Fairbairn that we owe our understanding of, and appreciation for, yet another aspect of the patient's intense attachment to the bad object, namely, her ambivalence. The bad object is a seductive object that initially excites but ultimately rejects. The

patient's libidinal ego will attach itself to the exciting object and long for contact, hoping against hope that the object will deliver. The patient's antilibidinal (or aggressive) ego will attach itself to the rejecting object and rage against it. In other words, the patient will have an intensely conflicted, highly ambivalent relationship with the bad object, to which she will be both libidinally and aggressively attached, a seductive object that she will both need because it excites and hate because it rejects (Fairbairn 1954).

In essence, the patient's relentless pursuit is of bad objects that initially tantalize by offering, whether explicitly or implicitly, verbally or nonverbally, the enticing promise of a certain kind of relatedness, only later to devastate by withdrawing the offer.

I would like now to present a clinical vignette that speaks poignantly to this issue of the patient's relentless pursuit.

Clinical Vignette: Her Tears and Mine

I have been seeing Sara, an extremely gifted 55-year-old therapist, four times a week for the past five years.

At the very beginning of our work together, I said something to Sara that made her feel I did not want to work with her. (I apologize for not being able to share with you the specifics of what I actually said, but Sara asked me,

please, not to. She did, however, give me permission to share with you what follows.)

Sara considers what I said to her in our third session those five years ago to have been a mistake for which she will never be able to forgive me, although she wishes desperately that she could.

At the time, I was horrified that Sara would have so *misunderstood* what I was saying, but, given what I have since come to know about her, I can now appreciate why what I said was indeed deeply hurtful to her.

Over the course of our years together, Sara has spent much time trying to decide whether or not she feels safe enough to continue our work. But, because of the *unforgivable* mistake that I made those five years ago, she fears she may never be able to trust me.

Although periodically I have attempted to clarify (rather defensively I'm sure) what I had thought I was trying to say in our third session those five years ago, understandably Sara has not been all that interested in listening and has held fast to her experience of me as untrustworthy and of the therapy as a place that is not safe – certainly not safe enough to bring her despair, her heartbreak, her loneliness, or her tears.

Over time, what Sara and I have come to understand about our dynamic

is that we have unwittingly re-created, between us, the mutually torturing relationship that she had with her toxic mother. At times, Sara is her bad mother and I am Sara who, as a little girl, was tormented by her double-binding mother. At other times, it is I who am her bad mother and Sara who is tormented by me as she was once tormented by her mother.

In my work with Sara, it has been extremely important to her that I be able to confirm her experience of things, not just that I validate her perceptions as *plausible constructions* of reality (Hoffman 1983) but that I actually confirm them. In other words, Sara needs me to agree that her reality is *the truth*. Otherwise, she begins to feel crazy.

Almost without fail I have been able to confirm Sara's perceptions, most of which have seemed to me to be uncannily on target.

Unfortunately, some of her uncannily accurate perceptions have been about me. Although it is more difficult when the focus is on me and my vulnerabilities, ultimately (with the one exception to which I have already referred) I have been able – and willing – to confirm these perceptions as well.

As an example of how Sara will zero in on me: When she came to a session recently and asked to schedule a number of extra sessions, I was obviously very pleased. I actually said something to the effect of “Yes! Yes!

Yes!” Indeed it meant a great deal to me that she would want the extra time, particularly in light of her experience of me as someone who had failed her so unforgivably early on in our relationship.

So we scheduled the extra sessions and then I said, gently, “You know that I am so pleased to be scheduling the additional appointments, but it occurs to me that I should be asking you how you feel about having these extra sessions.”

Sara did not answer for a long time. After what seemed like an eternity to me, she said finally, and with much sadness, that she was now not sure the extra sessions were such a good idea after all, because she was suddenly feeling that maybe I did not really want her to be coming for the additional appointments.

Although I was initially stunned by her response, in time she helped me to understand something that I had not previously understood, namely, that by asking Sara to share with me how she felt about having the extra sessions, I was, in a way, humiliating her. Obviously she would not have asked for this extra time if a part of her had not wanted the additional contact with me. So for me to be now asking of her that she admit to wanting more time with me was to shame her for having desire in relation to me. Indeed, had I thought more about my somewhat formulaic question in advance, then I would

probably have known not to ask it.

What I now understood was that in asking her to tell me how she was feeling about getting the extra time, I really was more *going by the book* than *coming from my heart*. You see, I had been taught that it is always important to explore whatever underlying expectations, hopes, and fears the patient might be having whenever she asks for something from her therapist. So I really was more going by the book than by what I knew deep inside of me, namely, that despite Sara's deep reservations about me, a part of her was beginning to trust me a little more and was wanting me to know this without her having to say it outright.

Indeed, I came to see that Sara's experience of me as having shamed her was not just a story about her but also a story about me. I was able to understand that I really was shaming her by asking of her that she acknowledge wanting to have the extra time with me.

Sara has been a wonderful teacher. She has devoted considerable time and energy to teaching me to be a better therapist to her and, in all honesty, a better therapist period. I am so much wiser for my time with her. I am increasingly coming to see how often I will unconsciously fall back on going by the book instead of coming from my heart, not always in big ways, but in little ways, some of the rituals, some of the routines that I will find myself

doing, without really thinking them through.

Over the course of our five years together, four times a week, we have accomplished a lot, and, in Sara's life on the outside, she has been able to make some fairly dramatic and impressive changes.

But there has been this ongoing issue between us that we have not yet been able to resolve, namely, what to do with respect to the unforgivable mistake I made those numbers of years ago, about which I feel absolutely terrible and for which I have apologized many times over from the bottom of my soul.

Periodically Sara will turn to me and ask, point-blank, that I confirm her perception of me as having failed her unforgivably in that third session those five years ago. Over the years, she has made it very clear that were I to confirm that perception, she would have no choice but to terminate her treatment with me. On the other hand, when I do not confirm that perception, she feels she has no choice but to continue to feel unsafe, angry, and desperately unhappy.

When Sara and I get into this place, as we have so many times over the course of our years together, my mind almost snaps from the pressure of how crazy-making the whole thing is. By asking of me that I confirm her perception of me as untrustworthy and of my early-on mistake as

unforgivable, Sara puts me in an untenable position. But by the same token, by wishing deep within myself that Sara would someday both trust me and forgive me, I put Sara in an untenable position. She asks of me something that I cannot possibly do, but then I ask of her something that she cannot possibly do.

It is indeed agony for us both, yes, but it is also telling, telling us a great deal about the toxic relationship she had with her mother. And I believe we are doing the work that needs to be done, namely, attempting to negotiate our way through and out of this convoluted, mutually torturing, hopelessly enmeshed relationship that is, in actual fact, a re-creation of the double-binding, no-win relationship she had with her mother. It is a mutual enactment in which both of us are participating.

But by way of the drama that is being re-enacted between us, Sara is enabling me to experience, firsthand, what the experience must have been like for her in relation to her mother. We will need someday to find our way out of this Catch-22 situation but, for now, we must both sit with the uncertainty of not knowing what will ultimately unfold.

The other day, however, something different did happen. Sara was once again begging me to admit that what I had said to her those numbers of years earlier was unforgivable. As I listened, I found myself feeling suddenly so sad,

so trapped, so anguished, and so tormented that I suddenly burst into tears. I rested my head in my hands and just sobbed. Sara sat there very still, barely breathing, watching, waiting. Eventually I stopped, and we continued our talking. This time I knew not to ask her the pat question, “How was it for you, my crying?”

Later in the session, however, I think Sara showed me what it must have been like for her. She herself began to cry. She put her head in her hands and wept. Now it was I who sat there, very still, barely breathing, watching, waiting. But what made it particularly poignant for me was my knowing that she, as an adult, had never before cried in front of anyone.

Our work continues.

Fairbairn’s Intense Attachments

In order better to appreciate what fuels the intensity with which relentless patients pursue the (bad) object of their desire, I would like to turn now to W.R.D. Fairbairn (1954), who is perhaps best known for his delightfully pithy “A bad object is infinitely better than no object at all,” a concept that, I believe, accounts in large part for the relentlessness with which patients pursue the unattainable – both the relentlessness of their unrealistic hope and entitled sense that something is their due and the relentlessness of their scathing outrage in the face of its being denied.

Over the years many psychoanalysts have written about internal bad objects or pathogenic introjects to which the patient is intensely attached but few have addressed the critical issue of what exactly fuels these tenacious attachments.

It is to Fairbairn that we must therefore look in order to understand the nature of the patient's intense attachment to her internal bad objects, an attachment that makes it difficult for her both to separate from the now-introjected infantile object and to extricate herself from her compulsive repetitions.

How Bad Experiences Are Internally Recorded and Structuralized

Let me review what Fairbairn has to say about how bad experiences at the hands of the infantile object are internally recorded and structuralized.

Says Fairbairn: when a child's need for contact is frustrated by her mother, the child deals with her frustration by introjecting the bad mother. It is as if the child finds it intolerably painful to be disappointed by her mother, and so the child, to protect herself against the pain of having to know just how bad her mother really is, introjects her mother's badness in the form of an internal bad object. Basically, the child takes the burden of her mother's badness upon herself in order not to have to feel the pain of her grief.

First Line of Defense: Introjection of the Parent's Badness

Defensive introjection of the parent's badness happens all the time in situations of abuse. The patient will recount episodes of outrageous abuse at the hands of a parent and then report that she feels, not angry at the parent, but guilty for having somehow provoked it, for having gotten in the way, for having had too many needs, for having been too difficult, or, even, for having been alive. Again, it is easier to experience herself as bad (and unlovable) than to allow herself to know the truth about her parent as bad and unloving. It is easier to experience herself as having deserved the abuse than to confront the intolerably painful reality that the parent should never have done what she did.

More generally, a child whose heart has been broken by her parent will defend herself against the pain of her grief by taking on the parent's badness as her own, thereby enabling her to preserve the illusion of her parent as good and as ultimately forthcoming if she (the child) could but get it right. In essence, by introjecting the bad parent, the child is able to maintain an attachment to her actual parent and, as a result, is able to hold on to her hope that perhaps someday, somehow, some way, were she to be but good enough, try hard enough, be persuasive enough, suffer long enough, she might yet be able to compel the parent to change.

Maintaining the Infantile Attachment

After all, if the badness now resides within the child and not the mother, then the child can at least cherish the hope that she might yet be able to master or control that badness, were she to be but good enough. Introjecting the bad object enables the child to maintain her infantile attachment to the now-introjected object, makes it possible for her to avoid separation from the object, and fuels her belief that the locus of control can now be an internal one.

Illusions of Grandiose Omnipotence

By clinging to her hope that she might yet be able to force the parent to relent, the child is preserving her grandiose illusions of omnipotent control. Because, as we had noted earlier, the child's greatest need is for contact, separation is her greatest fear. The child experiences the infantile object as absolutely essential for her survival. Were she to disengage herself entirely from the infantile object, were she to renounce her dependence upon the object, in her eyes such renunciation would be tantamount to forfeiting all hope of ever securing gratification of her unsatisfied longing for connection, acceptance, and love. And so it is that the child remains intensely attached to the now-introjected bad object.

A Bad Object Is Infinitely Better Than No Object at All

Although the child is devastated by the object's failure to deliver, as

Fairbairn observes, a relationship with a bad object is infinitely better than no relationship at all because, although the object is bad, the child can at least still hope that maybe someday, somehow, some way, the object will be good.

Fairbairn vs. Kohut

Compare what Fairbairn is saying here to what Kohut has to say about how the child attempts to master her experience of disappointment at the hands of her parent. Kohut (1966) suggests that when the parent has been good and is then bad, the child, in an effort to master her disappointment in the parent, takes in the good that had been there prior to the introduction of the bad. Fairbairn (1954), on the other hand, suggests that when the parent has been good and is then bad, the child, in an effort to master her disappointment in the parent, takes in the bad. These are obviously two entirely different conceptualizations of the process by which the child attempts to master her experience of disappointment at the hands of the frustrating parent.

Perhaps a way to reconcile these two seemingly opposing perspectives is to consider Kohut and Fairbairn to be addressing different clinical situations.

Nontraumatic (Optimal) vs. Traumatic Frustration

Crucial here is the distinction Kohut makes between nontraumatic frustration and traumatic frustration. Kohut posits that if a frustration can be worked through by way of grieving, then it should be deemed a nontraumatic frustration; if, however, a frustration cannot, for whatever complex mix of reasons, be worked through and resolved, then it should be deemed a traumatic frustration.

Kohut's belief is that nontraumatic, or optimal, frustration (that is, frustration properly grieved) prompts the child to internalize the good parent. But what does Kohut suggest happens in situations where the frustration cannot be properly grieved and ultimately mastered? First of all, Kohut suggests that there is a reinforcement of the narcissism (that is, an intensification of the need to find an object to complete the self), to which he refers as defensively reinforced narcissism. But what does Kohut suggest gets internalized when there has been a traumatic frustration? Actually, he believes that nothing gets internalized, certainly not the good parent but not the bad parent either!

In other words, we know the good object does not get internalized, which gives rise to the internal absence of good (impaired capacity or structural deficit). But, according to Kohut, neither is the bad object internalized. Recall that in self psychology, there are no bad objects; there are no pathogenic introjects, only defensively reinforced narcissistic needs,

because traumatically frustrated needs become intensified, and structural deficits, because the good object does not get internalized.

Reconciling the Differing Perspectives of Kohut and Fairbairn

So how do we reconcile Kohut's contention that in an effort to master her disappointment, the child will take in the good object with Fairbairn's contention that in an effort to master her disappointment, she will take in the bad object?

I would like to propose that we use Fairbairn's theory to inform our understanding of what gets taken in when the child's needs are traumatically frustrated. Fairbairn does not make explicit the distinction between nontraumatic and traumatic frustration, but I believe that his is nonetheless a theory about what happens in situations of traumatic frustration, namely, in an effort to master her disappointment, the child takes the burden of the parent's badness upon herself in the form of internal bad objects or pathogenic introjects, which create the internal presence of bad.

Adapting by Internalizing Good vs. Defending by Introjecting Bad

From this it follows that instead of adapting to the loss by internalizing the good, the patient defends against the pain of her grief by introjecting the bad. Kohut's interest is in adaptive structure-building (transmuting)

internalization of the good, whereas Fairbairn's interest is in defensive introjection of the bad. Kohut's interest is in the development of healthy psychic structure (adaptive internal capacity), whereas Fairbairn's interest is in the development of psychopathology (defensive internal badness).

Ambivalent Attachment to the Seductive Object

Returning now to a consideration of what Fairbairn suggests is the specific nature of the child's intense attachment to this defensively introjected bad object, as we have just seen, the child who has been failed by her parent takes the burden of the parent's badness upon herself. Introjection is therefore the first line of defense.

A Seductive Parent – Who First Says “Yes” and Then Says “No” – Is a Very Bad Parent

Moments ago I had suggested that according to Fairbairn, a bad parent is a parent who frustrates her child's longing for contact. But, says Fairbairn, a seductive parent, who first says yes and then says no, is a very bad parent.

Fairbairn's interest is in these very bad parents, these seductive parents. And so, more specifically, when the child has been failed by a parent who is seductive, the child defensively introjects this exciting but ultimately rejecting parent.

Second Line of Defense: Splitting

Splitting is the second line of defense. Once the bad object is inside, it is split into two parts: the exciting object that offers the enticing promise of relatedness and the rejecting object that ultimately fails to deliver. Two questions. Is the rejecting (depriving) object a good object or a bad object? Yes, a bad object. Is the exciting (enticing) object a good object or a bad object? Actually, it too is a bad object!

Splitting of the ego goes hand in hand with splitting of the object. The so-called libidinal ego attaches itself to the exciting object and longs for contact, hoping against hope that the object will come through. The antilibidinal ego, which is a repository for all the hatred and destructiveness that have accumulated as a result of frustrated longing, attaches itself to the rejecting object and rages against it.

Fairbairn's Ego as a Dynamic Structure

Recall that Fairbairn does not conceive of the id as separate from the ego. Rather, he posits the existence of an ego that has not only internal objects but also its own energy – a dynamic structure.

So what, then, is the nature of the patient's attachment to the bad object? It is, of course, ambivalent: it is both libidinal and antilibidinal or

aggressive in nature. The bad object is both needed because it excites and hated because it rejects. Alternatively, we could say that the bad object is both loved because it is needed and hated because it is needed.

Fairbairn vs. Kernberg

Please note that Fairbairn uses the concept of splitting very differently from Kernberg. Kernberg (1995) uses splitting to describe the primitive and pre-ambivalent manner in which borderlines relate to their objects, namely, as either all-good or all-bad objects. Kernberg's all-good object gratifies the patient's need and, in the moment, is therefore invested with libidinal energy; Kernberg's all-bad object frustrates the patient's need and, in the moment, is therefore invested with aggressive energy. So the good object is libidinally cathected and the bad object is aggressively cathected. In contradistinction to this is Fairbairn's notion that the bad object is an ambivalently held object; it is both libidinally cathected (by the libidinal ego) and antilibidinally or aggressively cathected (by the antilibidinal ego).

So we have established that, according to Fairbairn, introjection and splitting are the first and second lines of defense against the intolerably painful experience of a mother who says first yes and then no, of a mother who first entices through the promise of a certain kind of relatedness and then devastates through the withdrawal of such a promise.

Third Line of Defense: Repression

The third line of defense is repression, that is, repression of the ego's attachment to the exciting/rejecting object.

At the Core of the Repressed Is a Forbidden Relationship

According to Fairbairn, then, at the core of the repressed is not an impulse, not a trauma, not a memory; rather, at the core of the repressed is a forbidden relationship, an intensely conflicted relationship with a bad object who is both loved and hated. Such a relationship involves both longing and aversion, desire and revulsion, although, because the attachment is repressed, the patient may be unaware that both sides exist.

Clinical Vignette: The Need to Acknowledge Love for the Man Who Betrayed Her

For years now, Melinda has been involved in one relationship after the next with abusive men. We find out that her father had sexually abused her when she was five. She is aware of hating him and of feeling absolute and utter contempt for him, but she has no memory of having ever had desire in relation to him.

Before she can truly renounce him and, in the process, relinquish her pattern of involvement with abusive men (her repetition compulsion), she

must recover her long-repressed yearning to be close to him. She must eventually acknowledge that she had once loved him, before he had then exploited that love and broken her heart. Otherwise, she will be destined for always to be contaminating her present with the past as she compulsively plays out this unresolved childhood drama in the here-and-now with every man she chooses to love. She will be destined (1) to choose good men and then to experience them as bad, (2) to choose good men and then to behave in such a fashion as to get them to become bad, or, simply, (3) to choose bad men.

But until she can allow herself to remember that she had once longed to be close to her father and to grieve the heartache he caused her by virtue of his devastating betrayal of her, she will be unable both to separate from him and to extricate herself from her compulsive repetitions.

What this means clinically is that patients who are relentless in their pursuit of the bad object must ultimately acknowledge both their longing for the object and their upset and anger in the aftermath of the object's failure of them.

So it is to Fairbairn that we turn in order better to understand that the intensity of the patient's attachment to the bad object is fueled by ambivalence.

The Relentless Pursuit of the Sadomasochist

From Fairbairn, then, we learn that the patient's relentless pursuit is of ambivalently held exciting/rejecting objects, seductive objects that initially tantalize by offering the enticing promise of a certain kind of relatedness, only later to devastate by pulling back.

Schizoid vs. Sadomasochistic Psychodynamics

Interestingly, although Fairbairn's claim is that he is writing about schizoid personalities (individuals whose attachments are to internal, not external, objects), I believe that the manner in which he conceptualizes the *endopsychic situation* of these so-called schizoid personalities captures, in a nutshell, the psychodynamics of sadomasochistic patients.

My contention is that the patient's relentless pursuit of the bad object has both masochistic and sadistic components. This bad object will be both narcissistically cathected, to which Winnicott's ideas about illusions of grandiose omnipotence speak, and ambivalently held, to which Fairbairn's ideas about seductive (exciting/rejecting) objects speak.

Relentless Hope Fuels Masochism

More specifically, the patient's relentless hope, which fuels her masochism, is the stance to which she desperately clings in order to avoid

confronting certain intolerably painful realities about the object and its separateness, and her relentless outrage, which fuels her sadism, is the stance to which she resorts in those moments of dawning recognition that the object is separate and unyielding.

I do not limit sadomasochism to the sexual arena; rather, I conceive of sadomasochism as a relational dynamic that gets played out, to a greater or lesser degree, in most of the patient's significant relationships, particularly with objects that are narcissistically cathected (and therefore experienced by the patient as residing within her sphere of omnipotent control) and ambivalently held (and therefore cathected with both libido and aggression).

Untamed Libido vs. Untamed Aggression

As will soon become apparent, whereas masochism is more a story about unbridled libido (and positive cathexis of the love-hate object), sadism is more a story about unbridled aggression (and negative cathexis of the love-hate object).

Masochism and Sadism Coexist

Masochism and sadism always go hand in hand, although the patient may appear to be simply masochistic. In other words, the masochistic defense of relentless hope and the sadistic defense of relentless outrage are flip sides

of the same coin; they are both defenses and speak to the patient's refusal to confront the pain of her grief about the object's refusal to be possessed and controlled, the pain of her grief about the object's refusal, ultimately, to allow itself to be shaped by the patient's need for the good (responsive) parent whom she should have had reliably and consistently early on but never did.

Masochistic Hoping Against Hope

More specifically, masochism is a story about the patient's hope, her relentless hope, her hoping against hope that perhaps someday, somehow, some way, were she to be but good enough, try hard enough, be persuasive enough, persist long enough, suffer deeply enough, or be masochistic enough, she might yet be able to extract from the object (sometimes the parent herself, sometimes a stand-in for the parent) the recognition and love denied her as a child – in other words, that she might yet be able to compel the immutable object to relent.

And so, even in the face of incontrovertible evidence to the contrary, the patient pursues the object of her desire with a vengeance, the intensity of this relentless pursuit fueled by her entitled conviction that the object could give it (were the object but willing), should give it (because this is the patient's due), and would give it (were she, the patient, but able to get it right). The patient refuses to let herself know the truth, instead defending against it by

becoming relentless.

Masochistic Investment in Hope, Not in Suffering

Please note that the patient's investment is not so much in the suffering per se as it is in her passionate hope that perhaps this time...

Sadism Fueled by Relentless Outrage

Sadism is, then, the patient's reaction to the loss of hope she experiences in those moments of dawning recognition that she is not actually going to get what she had so desperately wanted and felt she needed to have in order to go on, in those moments of anguished heartbreak when she is confronted head-on with the inescapable reality of the object's separateness and refusal to relent.

Sitting with the Pain of Disappointment vs. Playing It Out on the Stage of One's Life

Instead of sitting with the pain of her disappointment, the aggrieved patient, convinced that she has been misunderstood, abandoned, betrayed, or victimized, becomes outraged and intent upon retaliation. Instead of grieving, she becomes angrily preoccupied with grievances. Indeed, it could be said that suffering itself, tinged as it is with both libido (to the extent that it is relentlessly self-indulgent) and aggression (to the extent that it is relentlessly

self-destructive), is a defense against grieving.

The Healthy Response to the Thwarting of Desire

What is the healthy response to frustration, loss, and thwarting of desire? A person who has been told “no” must confront the pain of her disappointment in the object and come to terms with it, feeling all that she must in order, ultimately, to make her peace with the reality of it; in other words, she must grieve this thwarting of her desire.

And if she can make her peace with just how devastated and enraged she is, then she will be able to internalize the good that she had experienced in the relationship prior to her disillusionment, adaptive internalizations that will enable her to preserve internally a piece of the original experience of external goodness. Such transmuting (structure-building) internalizations are an important part of the grieving process and of how the person masters her experience of disappointment and heartbreak. She must experience, to the very depths of her soul, her anguish, her heartbreak, and her anger that things were as they were and are as they are. The patient must ultimately make her peace with the sobering reality that, because of early-on parental failures in the form of both presence of bad (trauma and abuse) and absence of good (deprivation and neglect), she now has psychic scars that may never entirely heal and will most certainly make her journey through life rather more

difficult than it would otherwise have been.

Beckmann (1990) has suggested that “Grieving is nature’s way of healing a broken heart.”

The Developmental Task and the Therapeutic Task

Indeed, growing up (the task of the child) and getting better (the task of the patient) have to do with mastering the devastation and anger that accompany the recognition of just how limited, just how imperfect, and, ultimately, just how separate, immutable, and unrelenting one’s objects, both past and present, really are – a protracted grieving process that involves confronting and eventually making one’s peace with the sobering reality that, at the end of the day, one’s objects will never be all that one would have wanted them to be (Stark 1994a, 1994b, 1999).

Transformation of the Need to Hold On into the Capacity to Let Go

In fact, it could be said that maturity involves transforming the defensive need to have one’s objects be other than who they are into the adaptive capacity to accept them as they are – transformation of the unhealthy need to possess and control one’s objects into the healthy capacity to relent, forgive, accept, grieve, internalize what good there was, separate, let go, and move on, richer and wiser for having had the experience, even if

sadder and more sober.

In other words, it could be said that maturity is an adaptation to the impact of painful truths; it requires the acceptance of realities that sober and sadden.

When the Pain of Loss Is Simply Too Much

But a person who cannot tolerate the experience of heartbreak will be unable to manage her grief. Such a person, unable to adapt to the reality that her objects will never be all that she would have wanted them to be, must therefore defend herself against the knowledge of that intolerably painful reality. And so, instead of confronting the pain of her disappointment, grieving the loss of her illusions, adaptively internalizing what good there was, and relinquishing her pursuit, the relentless patient does something else.

Sadistic Unleashing of a Torrent of Abuse

With the dawning recognition that the object can be neither possessed and controlled nor made over into what she would have wanted it to be and powered by her conviction that she has been had (that is, duped, conned, seduced, betrayed, rejected, abandoned), the patient will defensively react with the sadistic unleashing of a torrent of abuse directed either in fact or in fantasy toward either herself for having failed to get what she had so

desperately wanted or toward the disappointing object for having failed to provide it. She may alternate between enraged protests at her own inadequacy and scathing reproaches against the object for having thwarted her desire.

In other words, when the patient's need to possess and control the object is thwarted, what will come to the fore will be her need to punish the object by attempting to destroy it.

The unleashing of her abusiveness will be fueled by her belief either that she has no choice but to lash out against the object (because it has hurt or wronged her) or that she is entitled to lash out against the object (because it is now her turn to do the hurting of someone else).

In essence, sadism is the relentless patient's defensive reaction to disappointment and the loss of hope.

Clinical Vignette: Ferreting Out the Underlying Trigger – How Have I Failed You?

So, during a therapy session, if the patient suddenly becomes abusive, what question might the therapist think to pose?

If the therapist asks the patient "How do you feel that I have failed you," at least she will have known enough to ask the question, but she is also

indirectly suggesting that the answer will be primarily a story about the patient and the patient's perception of having been failed.

Better therefore to ask, "How have I failed you?" Here she will be signaling her recognition of the fact that she herself might well have contributed to the patient's experience of disillusionment and heartache, perhaps, say, by not fulfilling an implicit promise earlier made or by refusing to acknowledge her unrelenting commitment to a certain perspective or by failing to admit to a mistake or error in judgment or by denying her own contribution to a therapeutic impasse. The therapist must have both the wisdom to recognize and the integrity to acknowledge, certainly to herself and perhaps to the patient as well, the part the therapist herself might have played in the drama being re-enacted between them, by first seductively stoking the flames of the patient's desire and then devastating the patient through her failure, ultimately, to deliver.

The Sadomasochistic Cycle

In any event, the sadomasochistic cycle is repeated once the seductive object throws the patient a few crumbs. The sadomasochist, ever hungry for such morsels, will become once again hooked and revert to her original stance of suffering, sacrifice, and surrender in a repeat attempt to get what she so desperately wants and feels she must have in order to go on.

Internal vs. Relational Sadomasochistic Dynamics

To this point, my focus has been on the way sadomasochism manifests itself relationally and we have used Fairbairn to help us understand the underlying endopsychic situation, namely, that the patient has both a libidinal and an aggressive attachment to the bad object (thus the ambivalence of her attachment and the relentlessness of her pursuit). I hypothesize that these same patients have both a libidinal and an aggressive attachment to the bad self, manifesting as self-indulgence on the one hand and self-destructiveness on the other.

As an example of this latter, consider a patient with a seemingly intractable eating disorder, one that compels her sometimes to binge, thereby gratifying her libidinal need to self-indulge, and sometimes to restrict, thereby gratifying her aggressive need to self-punish.

Self-Indulgence Alternating with Self-Destructiveness

The vicious cycle might then go as follows: After the patient has been on a diet for a while, she will begin to feel deprived, will become resentful, and will then feel entitled to gratify herself by indulging in compulsive overeating, which will then make her feel guilty and anxious and prompt her to punish herself by severely restricting her calories once again, which will then make her feel deprived, angry, and entitled to indulge in yet another eating binge,

and so on and so forth. A roller-coaster ride, iterative cycles of deprivation prompting self-indulgence prompting guilt prompting self-punishment – deprivation, self-indulgence, guilt, self-punishment.

In other words, sadomasochism can be played out either relationally (in the form of alternating cycles of relentless hope and relentless outrage) or internally (in the form of alternating cycles of self-indulgence and self-destructiveness). On the one hand, when our focus is on the way in which unresolved grief gets played out in one's relationships with others, we speak of the masochistic defense of relentless hope and the sadistic defense of relentless outrage; but, on the other hand, when our focus is on the way in which unresolved grief gets played out in one's relationship with oneself, we speak of the masochistic defense of relentless self-indulgence and the sadistic defense of relentless self-torment.

Confronting the Reality of the Object's Limitations and the Reality of One's Own

By the same token, when sadomasochism is played out relationally, the patient must ultimately confront – and grieve – the reality of the object's limitations and arrive at a place of serene acceptance of the object's flaws, imperfections, and inadequacies, but when sadomasochism is played out internally, the patient must ultimately confront – and grieve – the reality of her own limitations and arrive at a place of humble acceptance of her own

flaws, imperfections, and inadequacies.

Unrelenting Self-Sabotage, Whether Manifesting Relationally or Internally

In either case, whether the sadomasochism is played out relationally or internally, the net result of the patient's ambivalent attachment to the bad object and her ambivalent attachment to the bad self will be unrelenting *self-sabotage*. The relentless patient will unwittingly and compulsively re-enact on the stage of her life all manner of dysfunctional relational patterns and self-defeating behaviors because refusing to let herself know the truth, whether about others or about herself, she will be ever busy re-creating the early-on traumatic failure situation of seductive pleasure and excitement followed by heartbreaking rejection and pain. Under the sway of the repetition compulsion, the relentless patient will put herself in the position, again and again, of wanting what she cannot have and refusing to let go.

Albert Einstein was speaking to these relentlessly self-defeating dynamics when he defined insanity as "doing the same thing over and over again and expecting different results."

Clinical Vignette: Relentless Pursuit of the Empathic Grunts

I would like to offer a clinical vignette about a patient who was relentless in his pursuit of that which he could never have but to which he

nonetheless felt entitled, a man who had not yet confronted the pain of his early-on heartbreak in relation to his father.

The patient, Dr. Mark Brown, is a man on whom I did a consultation several years ago. He is a psychiatrist, had been in analysis for some eight years with a well-known and highly respected local training analyst, and was feeling very stuck in his treatment. He explained to me that he was becoming increasingly dissatisfied with his analyst because he was not getting the kind of support he wanted and felt he deserved.

By way of illustration, Dr. Brown cited a time when he had gone to his analyst's office, had lain down on the couch, and had told his analyst in some detail about the very difficult day he had been having. He had had three admissions to write up, he had been reprimanded by the attending, when it came time to leave for his analytic hour he had found that his car had been blocked in by other cars so that he had had to take a taxi in order to be on time, in the confusion he had lost his wallet and therefore had had to beg the cab driver to accept a check, and so on and so forth.

In his consultation with me, Dr. Brown expressed his outrage and his bitterness, protesting that all he had wanted from his analyst was an empathic grunt, some acknowledgment of how frustrated and angry he must have been feeling because of the horrid day he was having. The patient

demanded to know, “Was that too much to ask? All I wanted was a little kindness, a little compassion!”

Dr. Brown went on to talk about how his colleagues had confirmed his belief that if his analyst could not give him even this, then he (the patient) had no business remaining in such a disappointing relationship, that it was masochistic for him to be continuing the treatment.

But as Dr. Brown’s story unfolded, I came to see things in a somewhat different light. Admittedly, it does not seem unreasonable to be asking for a bit of support, understanding, and comfort at a time when you are feeling overwhelmed and agitated. But for the patient to be looking for such support from someone whom he knew did not give that kind of support, although the analyst did offer many other good things, for the patient to be looking still, even after these eight years, for support from someone whom he knew had never given that kind of support – this is what caught my attention! This is what seemed to me to be masochistic.

So whereas Dr. Brown was thinking that it was masochistic for him to be staying in a relationship with someone who was not giving him what he so desperately wanted, I was beginning to think that it was masochistic for the patient to be still wanting that which he was clearly never going to get, and that the solution lay not necessarily in severing the relationship with his

analyst but, first, in facing the reality that he was never going to get exactly what he would have wanted and, then, in grieving that. The patient would get other good things from his analyst and, in fact, over the course of the previous eight years, had gotten all sorts of good things from him – but never those empathic grunts.

Admittedly, I also wondered a bit about the analyst's seeming refusal to relent, refusal to allow himself to be influenced even a little by the patient's impassioned entreaties, but, in this particular instance, I decided not to focus on what I suspected was the analyst's contribution to the stalemated situation between them. My fear was that were I to speak too much to the part I sensed his analyst might be playing, the patient might use this to reinforce his own rather entrenched position, which would then obscure the more important issue of his accountability for his own relentlessness, fueled by his refusal to confront the reality of his analyst's limitations.

And so I said that, at this point, I believed the work of the analysis involved Dr. Brown's confronting, head-on, the excruciatingly painful reality that his analyst was never going to give him exactly what he wanted. I also said I suspected that the analyst was a stand-in for one or both of his parents and that his experience of thwarted longing in relation to his analyst was the recapitulation of an early-on and never grieved heartbreakingly painful relationship with a parent.

Although in the first of his three consultation sessions with me Dr. Brown had said that as a result of the work he had done over the course of the previous eight years he felt he had pretty much made his peace with his parents' very real limitations, when I now framed the stalemated situation in his analysis as speaking perhaps to frustrated desire and unrequited longing with respect to a parent, he began to resonate with this.

Somewhat shaken, Dr. Brown, now in the third and final session of our consultation, finally acknowledged that, indeed, he had always been frustrated in his desire to get recognition from his father, a narcissistic man who was chronically depressed and totally unavailable for support or comfort. As the patient now talked about his father, he began to express what he said he had always known on some level but had never really been able to let himself think or feel, namely, that his heart had been broken by his father's failure of him, his father's inability to respond to his desperate pleas for attention and love.

As our session continued, it became very clear that although Dr. Brown had given lip service during the eight years of his analysis to acknowledging how devastated he had been by his father's emotional remoteness, he had never really let himself feel just how traumatizing his father's inaccessibility had actually been for him.

Furthermore, the patient's refusal to grieve that early-on failure was forcing him to relive it in the here-and-now of the transference, and intensifying that early pain, but now in relation to his analyst.

As we explored other areas of Dr. Brown's life, we came to see that it was a recurring theme for him to be ever wanting from his objects the one thing they would never be able to give, a recurring pattern for him to be ever in a state of frustrated longing and thwarted desire in relation to the significant people in his life.

I suggested to Dr. Brown that before he made a decision about whether or not to continue with his analyst, he should use the analysis to make his peace with just how disappointed he was in his analyst. I told him I thought that in the process he would also be doing some important, even if belated, grief work around the emotional unavailability of his father.

So I suggested that instead of immediately rushing off to another analyst in order to pursue his relentless search for gratification elsewhere, Dr. Brown should stay in the relationship with his current analyst at least long enough to gain insight into why he was always in the position of trying to extract the right thing from the wrong person, that is, why he was always in relentless pursuit of the unattainable.

In essence, I told Dr. Brown I thought he would need to take some

responsibility for the part he was playing in the unfolding of his life's drama, that he would need to take some ownership of his relentless hoping against hope that his analyst might someday turn out to be someone whom the patient knew (in his heart of hearts) the analyst would never, and could never, be, and that the patient would need, eventually, to confront the pain of his grief about his father and those he had chosen to be parent substitutes.

It could probably be said that a patient's relentless pursuit of the right things from the wrong people is the hallmark of one who, refusing to grieve, clings to his relentless hope.

The Therapist's Unwitting Seductiveness

Over time, I have increasingly come to appreciate that when a patient is in the throes of her relentless pursuit of the therapist, it is usually a story about not only the patient but also the therapist. The patient's contribution has to do, admittedly, with her refusal to take no for an answer; but the therapist may also be contributing by way of her unwitting seductiveness, whereby she initially offers (whether explicitly or implicitly, verbally or nonverbally) the enticing promise of a yes, only later to indicate no, thereby first unwittingly stoking the flames of the patient's desire and then devastating through her failure, ultimately, to deliver. In other words, the patient's relentlessness may be co-created, with contributions from both

patient and therapist.

The Therapist's Adaptive Capacity to Relent

My contention is that accountability on the part of both patient and therapist is at the heart of what heals. And I believe that if patient and therapist are ever to be able to wend their way out of their mutual enactments, it may well be necessary for the therapist herself to have the adaptive capacity to relent instead of the defensive need to persist – and, most probably, must relent first. How can we possibly expect our patients to hold themselves accountable if we ourselves are in denial and refuse to take responsibility for our actions?

The Grieving Process

In essence, confronting – and grieving – the reality of our limited power to make other people over into who we would want them to be are at the heart of the work the patient will need to do in order to extricate herself from her compulsive repetitions, her addictive dysfunctions, and her relentless pursuits.

In order to facilitate the patient's necessary grieving, the therapist may need to formulate interventions that provide an optimal mix of challenge and support: challenge in order to destabilize the patient's dysfunctional status

quo and then support in order to restabilize the patient at a higher level of awareness and acceptance (Stark 1994a, 1994b, 1999, 2015).

Therapeutic Challenge and Then Support

And so it is that the therapist will alternately challenge the patient by directing the patient's attention to where the patient isn't (that is, to acknowledgment of the sobering reality of the object's limitations, separateness, and immutability) and then support the patient by resonating empathically with where the patient is (that is, with the devastating heartbreak the patient is experiencing as she begins to confront that painfully disillusioning reality). Challenging the patient will increase her anxiety, but supporting the patient will ease that anxiety and help to create a safe space into which the patient can deliver the pain of her grief and her heartbreak, ultimately relenting, accepting, internalizing what good there was, separating, letting go, and moving on.

“As you begin to confront the reality that Robert is not who you had thought he was, it breaks your heart and you find yourself wondering how you will ever be able to go on without him in your life.”

“In those moments when you let yourself remember just how limited your mother really is and just how defensive she can get whenever you try to hold her accountable, the pain goes so deep and you feel such despair.”

“You think about all the ways in which Jane has let you down, and you find yourself feeling really angry – and betrayed. How could she have treated you so badly!”

“As you begin to admit to yourself that probably your father will never recognize what it took for you to be able to accomplish all that you have, the disappointment that you feel is almost unbearable, especially because so much of what you did was to please him.”

Again and again, the therapist will first increase the patient’s anxiety by highlighting what the patient, at least on some level, really does know to be the devastating truth about the object and then decrease the patient’s anxiety by resonating empathically with the grief she is experiencing as she begins to face that sobering reality. The therapist, ever attuned to the patient’s affective experience in the moment, wants the patient to be able to feel that she (the patient) is not alone with the pain of her grief.

“As you begin to recognize that your mother, despite all that you’ve done in an effort to make her understand, is still off in her own self-absorbed world and pretty much oblivious to your appeals to be heard, you find yourself feeling both devastated and enraged.”

“As you become increasingly aware of the price you’ve paid for clinging to the hope that someday you might be able to get your father to love you,

your heart breaks and you find yourself going to a very dark and desperate place.”

Back and Forth – Back and Forth

Back and forth, back and forth, challenge then support, challenge then support, the therapist first directing the patient’s attention to disillusioning truths and then supporting the patient as the patient sits with and, at last, feels, to the depths of her soul, her devastating disappointment.

It is hoped that the patient, within the context of safety provided by the relationship with her therapist, will be able finally to access the reservoir of tears that have accumulated inside of her over time. It is hoped that the patient will be able to feel secure enough that she can dare to feel the sadness, the anguish, the regret, the torment, the fury, and the impotent rage that have been pent up inside of her for so long.

The patient must come to accept the reality that she is ultimately powerless to do anything to make her objects, both past and present, different. She can, and should, do things to change herself, but she cannot change her objects and she will have to come to terms with that sobering truth. Such is the work of grieving and mastering the experience of loss, disappointment, heartbreak, and defeat; such is the work of making one’s peace with reality and moving on.

Precipitating Collapse in Order to Trigger Recovery

The grieving process will involve these recursive cycles of challenge and then support, increasing the patient's anxiety and then decreasing it, precipitating disruption by reminding the patient of disillusioning truths and then facilitating repair by being present with the patient as she confronts the pain of her grief, first prompting defensive collapse and then triggering adaptive reconstitution at ever higher levels of nuanced understanding and sober acceptance.

Transformation of Defensive Need into Adaptive Capacity

It will be only once the patient has been able to process and integrate the dissociated grief that she will be able to relinquish her relentless pursuit of the unattainable. The patient will have transformed unhealthy defense into healthier adaptation once she has grieved and, in the process, developed a more refined awareness of the limitations inherent in relationship and a more evolved capacity to accept that which she cannot change.

The therapist's goal will have been to facilitate transformation of the patient's need to defend against the pain of her grief by clinging to her relentless hope into the capacity to adapt by confronting the pain of her grief and coming to a place of serene acceptance with respect to what the object cannot do and of appreciation for what it can. The bad news, of course, will be

the sadness the patient experiences as she begins to accept the sobering reality that disappointment is an inevitable and necessary aspect of relationship. The good news, however, will be the wisdom she acquires as she comes to appreciate ever more profoundly the subtleties and nuances of relationship and begins to make her peace with the harsh reality of life's imperfections. Sadder perhaps, but wiser too.

Conclusion

In a beautiful article entitled "The Refusal to Mourn," Sheldon Kopp (1969) writes "Genuine grief is the sobbing and wailing [that] express the acceptance of our helplessness to do anything about [our] losses. If instead, we whine and complain, insist that this cannot be, or demand to be compensated for our pain, then we are forever stuck with trying to redeem the past" (p. 30).

In truth, relentless hope is a defense to which many of us cling, to varying degrees, in order not to have to confront certain intolerably painful realities in our lives, particularly with respect to the objects of our desire.

When a patient is caught up in the throes of needing her objects (whether the infantile, a contemporary, or the transference object) to be other than who they are, the therapeutic process must be able to facilitate relinquishment of the patient's relentless pursuit and transformation of her

infantile need to possess and control her objects (and, when thwarted, her infantile need to retaliate) into the mature capacity to relent, accept, grieve, forgive, internalize whatever good there was, separate, let go, and move on – transformation of her defensive need to have things be a certain way into the adaptive capacity to make her peace with the way things are – transformation of her need to hold on into the capacity to let go.

From Relentlessness to Acceptance

As noted earlier, maturity involves transforming the need to have one's objects be other than who they are into the capacity to accept them as they are. It involves transforming relentlessness (a defense) into acceptance (an adaptation). It is by way of grieving that need is transformed into capacity, infantile need into mature capacity and realistic hope.

So if all goes well, it will be within the context of safety provided by her relationship with the therapist that the patient will be able, finally, to feel the pain against which she has spent a lifetime defending herself, in the process transforming both her relentless need to possess and control and, when thwarted, her retaliatory need to punish and destroy into the capacity to relent, accept, grieve, forgive, internalize what good there was, separate, let go, and move on.

Coming to Terms With Disillusioning Realities

In essence, the therapeutic action makes possible transformation of the patient's relentless hope and, when thwarted, her relentless outrage into the healthy capacity to accept the reality that her objects will never be all that she would have wanted them to be.

From Relentless (Infantile) Hope to Realistic (Mature) Hope

And it is by way of grieving that need is transformed into capacity – infantile need into mature capacity and realistic hope. In fact, Searles (1979) has suggested that realistic hope arises in the context of surviving disappointment.

I am here reminded of *The New Yorker* cartoon in which a gentleman, seated at a table in a restaurant by the name of The Disillusionment Cafe, is awaiting the arrival of his order. His waiter returns to the table and announces, “Your order is not ready, nor will it ever be.”

I conclude with the Serenity Prayer: “God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference” (Sifton 2005).

Chapter 2 – On the Capacity to Experience the Self as “Good Enough”

I would like to speak to how all of us deal with the feeling that, despite our best efforts, we are a disappointment to ourselves, are letting ourselves down, are not living up to our expectations. Perhaps our sense of failure relates to who we are or perhaps to what we are accomplishing; perhaps it relates to things we did or did not do in the past or perhaps to things we are or are not doing in the present.

I will go on to suggest that it will be by way of confronting – and grieving – the reality of our very real limitations that we will be able to transform our sense of ourselves as a failure into humble acceptance of the reality that, under the circumstances, we are being and doing the very best that we can and that we are indeed *good enough*. In essence, I will be suggesting that it will be by way of grieving that the need to be who we are not can be transformed not only into the capacity to accept the sobering reality of who we are, limitations, flaws, inadequacies, vulnerabilities, weaknesses, and all, but also the capacity to forgive ourselves.

Admittedly, for me to be here suggesting that we should at least attempt to come to terms with the reality of our very real limitations comes dangerously close to challenging the time-honored concept, best expressed by

Walt Disney, that “All our dreams can come true, if we [but] have the courage to pursue them” (Gabler 2007). To imagine that there might be limits to who we could be or to what we could do somehow goes against the grain. And the words of Sam Walton (the founder of Sam’s Club and Walmart) probably resonate for most of us: “High expectations are the key to everything” (Walton and Huey 1993).

From their earliest days, people from all walks of life are taught that part of the American dream has to do with living in a land where anything and everything is possible, where there is the freedom to go for it, whatever one’s age, race, gender, or socioeconomic class. The Nike slogan of “Just Do It” captures the essence of this upbeat and inspirational stance by implying that greatness is within reach of all those who try. Think big. Dream big. The sky is the limit, and those who strive will be rewarded. In fact, the “Just Do It” campaign launched by Nike in 1988 was selected as one of the top two taglines of the 20th century because it was thought to be both “universal and intensely personal” (von Borries 2004).

The “Good Enough Self”

As we know, Winnicott (1965) writes about the “good enough mother” who is able, reliably and consistently, to meet the needs of her young child; so too he writes about the good enough therapist who is able, reliably and

consistently, to meet the needs of her patient.

This object may not be perfect but is presumed to be good enough, even if sometimes flawed, imperfect, or limited. But that will be OK because the object is, after all, doing the best that it can. Nobody is perfect.

As a counterpoint to this concept of the good enough object, with inspirational input from my colleague, Dr. Patty Bresky, I have developed the concept of the “good enough self,” a concept that speaks to the capacity to experience the self as not always perfect, as often making mistakes, and as certainly limited in many ways, but as basically good enough, at least as long as one is doing the best that one can. Central to this concept is the idea of being able to forgive oneself (again and again) for being, sometimes, a disappointment....

Now I do not mean to be suggesting that telling ourselves we are *doing the best that we can* should be used as a rationalization for not trying hard enough or for not holding ourselves accountable.

Rather, the idea that we really are doing the best that we can is meant to be a story about forgiveness, compassion, acceptance, and self-love, that although (in the best of all possible worlds) we might have wanted to be a certain way or to accomplish a certain something, under the circumstances and for whatever complex mix of reasons, we are truly doing the very best

that we possibly can – and that this is truly good enough.

In the case vignette that follows, we will see that, at the point when the patient first presented to me for a consultation, she had spent a lifetime struggling to come to terms with a terrible thing that had happened when she was very young.

Clinical Vignette: Unbearable Guilt and Relentless Self-Punishment

Indeed, one of the most heartrending consultations I have ever done was on Alicia, who came to see me many years ago because she was haunted by a tragic event that had happened half a century earlier. Alicia presented as a strikingly attractive, elegantly refined, and immaculately dressed 58-year-old woman who held herself with grace and dignity. By dint of her razor-sharp intelligence and extraordinary hard work, she had established herself in a highly successful career but had no life partner and no family and suffered from multiple health problems, most notably malignant hypertension.

The Horrifying Accident

At the age of seven, Alicia had been involved in a horrific accident. She had been vacationing with her family at their summer cottage and was out slalom water skiing on the lake. In the water ahead and to the right, she had

seen something breaking the surface. Was it a rock? The end of a log? A clump of seaweed? She couldn't quite figure out what it was. Next thing she knew, she had run over it. Tragically, it had been a little boy out swimming whom she had decapitated with her ski, killing him instantaneously.

Alicia had then spent every single day of the next five decades brutally punishing herself, wracked with guilt, haunted by her shame, her blood pressure inching up year after year. She couldn't live with the knowing that she had done what she had.

All of the many therapists with whom she had consulted over the course of those years had done their best to reassure her, telling her that she had not been at fault. How could she have known? My God, she had been only seven at the time, a mere child. It was an accident. She had not tried to kill the little boy; she had to forgive herself.

But in her heart of hearts, Alicia knew that, although she had been only seven at the time, she was an experienced water skier and, had she chosen to do so, she could have steered clear of, and thereby avoided, that mysterious object in the water.

And so Alicia had spent a lifetime wrestling with her shameful secret, her inner demons, and her intense self-loathing, the knowing that she had been responsible for the death of that little boy, who, as it happened, lived

only several doors down from her family's cottage and had been her friend.

As I listened, my heart was breaking for this devastated, broken, guilt-ridden, tormented soul who lived every single day of her life with unspeakable grief and unbearable pain. I said very little as her story unfolded, but, with hand on my heart and tears in my eyes, I nodded my understanding. The horror of it. Her decades of guilt, shame, private grief, and relentless self-punishment.

When I finally spoke, I said, softly, that I got it, why she felt responsible for his death. I told her I understood why she was having such trouble forgiving herself, such trouble figuring out a way to live with herself, what with her knowing that she could have chosen to do something different but that she had not. I went on to say that it broke my heart to think that she had had to carry inside of her all these years her crippling guilt, her secret shame, and her unrelenting grief.

And then Alicia began to reveal more and more of the horrific and incriminating details about what had actually happened that fateful summer day on the lake... that as she had approached the object in the water ahead of her and to the right, she had found herself wanting to know what exactly it was. Always one for a challenge, she had decided to test her skills as a slalom water skier by seeing how close she could get to the object without actually

running it over. And so, even when she had gotten close enough to see that the thing in the water ahead of her was moving and possibly alive and even with her knowing that she could and should veer away from it, as if driven by some uncontrollable inner compulsion, she had made a split-second decision to jump the wake behind the boat and head straight towards it instead of staying inside the wake and carefully steering clear of the unknown object.

The Importance of Bearing Witness

While Alicia was recounting these more specific and revealing details with unflinching honesty and raw vulnerability, I sat very still, barely moving, barely breathing, just quietly taking it in and occasionally nodding. I knew that it was for me to be able, simply, to listen, to be present, to be there to help her bear the pain of it, the horror of it, the guilt of it, the shame of it and not to withdraw, not to recoil in horror. It was for me, simply, to listen with compassion and without judgment.

Alicia alternately wept, raged, wailed, howled, fell silent – decades of pent-up anguish, heartbreak, guilt, shame, fear, anger, torment, despair, loneliness, isolation, regret, and high blood pressure. My heart was breaking for that spirited little girl Alicia had once been and the solemnly dignified but privately broken woman who now sat before me – surrendering, at last, her long-held secret guilt and searing shame.

Alicia explained that she had robotically recounted her story to many over the course of the years but that it had always been an abridged version. She said she had held back for fear that people would not be able to bear the horror of it, that they would offer her pat reassurances that would make her feel even more misunderstood, disconnected, isolated, alone, and alienated.

As she wept, sobbed, and wailed, she and I both knew that she was releasing, at long last, the reservoir of tears, pain, heartbreak, and anguish that had been accumulating inside of her for decades. She had so needed to be able to tell her truth and she had finally found someone who was willing to listen – and to bear witness.

At the end of Alicia's harrowing narrative, exhausted from the effort of remembering but visibly relaxing as she revealed the devastatingly painful details, blow-by-blow, she said she suddenly felt a tremendous rush of relief, at having shared, finally, what had really happened those years earlier, a wondrous release followed by an exhilarating inner calm, sense of gentle peace, and serene acceptance. Alicia said she no longer felt quite as alone because now someone else knew the real story and the incriminating details about what she had never before dared to share with anyone; now someone else knew the truth about what had happened that day on the lake.

And then Alicia was done and ready to go. She had stayed for ten

sessions. I told her she would always be welcome to return, were she ever to want to. She said that meant a great deal to her. At the end of our last session, as Alicia was leaving, she lingered at the door for a moment to give me a heart-felt hug.

The Redirecting of Energy into More Constructive Pursuits

Alicia never came back but, in the interim, has referred me at least 15 of her friends and colleagues. Periodically, she will drop me a little note, repeating her gratitude that I was able to bear the horror of what she had done and, in that way, had helped her to make her peace with the crime that she knew she had committed, albeit with no malice or ill-intent, those 50 years earlier. In one of her notes she told me, with much pride, about the nonprofit organization that she had set up, shortly after we met, to help people who had survived the tragic loss of a loved one to deal with their heartbreak and grief. There also came a time when she informed me that her malignant hypertension was now gone and that her blood pressure had returned to normal!

I think of Alicia often and of how she was finally able, with incredible courage and integrity, to confront – and grieve – the haunting reality of her past, which allowed her not only to evolve to a place of self-forgiveness, humble acceptance, and inner peace but also to channel all that now freed-up

energy into the creation of her nonprofit! I believe that, in Alicia's case, an important part of what enabled her to find absolution was the opportunity she had to confess to someone who listened with compassion and without judgment – to someone who was able to be present with her as she dared to remember, dared to confront, dared to relive, and, finally, dared to relent and to forgive herself.

In truth, the Serenity Prayer – “God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference” (Sifton 2005) – is very apt here. Before I began to focus my attention on the concept of a good enough self, I had mistakenly assumed that the Serenity Prayer spoke primarily to the importance of our capacity to accept disappointing realities about the people in our world and to relinquish our relentless hope with respect to them. I had, rather naively, not fully appreciated that perhaps equally, if not more, relevant is the importance of our capacity to accept disappointing realities about ourselves.

Just as it is important for all of us to be able to let go of unrealistic expectations that we have of others, so too it is extremely important that we be able to let go of unrealistic expectations that we have of ourselves, that we be able to relent, that we be able to make our peace with the sobering reality of our very real limitations so that we can arrive ultimately at a place of forgiveness and serene acceptance – and an appreciation of the fact that we

are, after all, good enough.

In sum, the process of working through the stressful impact of painful realities and disillusioning truths about ourselves, as well as about others, will result in not only a letting go of unrealistic expectations but also a freeing up of energy, which can then be redirected into more constructive pursuits.

Kohut's Two Lines of Narcissistic Development

I am here reminded of Kohut's two lines of narcissistic development, whereby the narcissistic need for perfection of the object is thought to become transformed into the goals and aspirations of the ego ideal and the narcissistic need for perfection of the self is thought to become transformed into the ambitions and purposes of the ego. The goals and aspirations are the *ends*; the ambitions and purposes are the *means* (Kohut 1966).

Transforming Need into Capacity

As I understand it, Kohut is suggesting that the process of transforming the need for perfection into the capacity to tolerate imperfection involves a gradual working through of disappointment in both the *imperfect object* and the *imperfect self*, the net result of which will be not only reining in the *pursuit of perfection* but also, as unattainable expectations are decathected, a recathecting of more attainable ones.

We all grieve in our own way. But however we do it and however long it takes, ultimately, we must revisit, remember, relive, go into it, sit with it, be present with it, hold it, allow each thought and each feeling, relax into it, breathe through it, accept it, hold it, feel to the depths of our soul and in every one of our body's cells, the heartbreak, the devastation, the sadness, the anger, the rage, the outrage, the regret, the remorse, the *if onlys*, the shame, the guilt, the horror of it all that the world, that our lives, that the people we love, that we ourselves are so not the way we would have wanted them to be, that the world, that our lives, that the people we love, that we ourselves so often disappoint.

But by daring to face – and grieve – just how disappointed we really are, we will be able, ultimately, not only to tame our expectations so that our dreams will be more reality-based but also to tame the energy we have available to pursue those dreams. Ultimately, we will be able to move to a place of forgiveness, of relenting, of letting go, and of moving on, and we must do this again and again. It is an ongoing process of forgiving, relenting, letting go, and moving on and of accepting that we are, basically, good enough.

Clinical Vignette: Struggling to Maintain the Passion

I would like now to present Wendy, with whom I have worked for many years – a 50-year-old woman who is an exceptionally gifted (though

struggling) writer, divorced since 2009, mother of three, and a deeply thoughtful and evolved old soul.

For many years I worked face-to-face with Wendy three times a week, and then a dream job opened up for her in Paris. After much discussion, she decided to move with her children to France – but we agreed to have her write me (journal-style) every month and to return to the States to see me twice a year in person. We have done it this way since 2010, and it has worked out well.

In 2011, she met James, a university professor of art history and, himself, an exceptionally gifted (though struggling) sculptor – a dashing, handsome, strong, virile man – and they fell madly in love. Although not without significant challenge, until last summer Wendy had been managing – reasonably successfully – to juggle the numerous responsibilities of her high-pressure job, her burgeoning career as a published author, the demands (and joys) of being a parent to three awesome children, and the demands (and joys) of being a partner to a brilliant and wondrously complex man. But Wendy, acutely aware of the passing years, was always in conflict about scheduling time for her writing.

The End of a Dream

And then, last July, James, 13 years her senior, became suddenly very ill.

James, a good man with a kind soul and a loving heart, a powerful man who had always prided himself on his strength and his potency, developed a bad cancer that began to ravage – and weaken – his body. Determined to do the best that she possibly could to be a devoted partner to this dear man whom she had always loved with tenderness and passion, Wendy made the decision to put aside her writing in order to be by his side and to accompany him to his many medical appointments, chemotherapy sessions, radiation treatments, and follow-up visits.

Devastated by the erosion of his manliness, James became quite regressed, despite his desperate effort not to be. But the cancer had really taken its toll and he was becoming increasingly demanding and dependent, even as he was ever busy apologizing for being that way and for being disruptive to Wendy and her routine. Committed to her cherished James but also longing to get back to her writing and her deadlines, Wendy found herself torn apart inside.

A Perfect Storm

And then her daughter, by her ex-husband, develops a brain tumor and, very impressively and somewhat surprisingly, handles it like a little trooper. There is some real concern that Elise might actually die, but the surgery is successful and she survives. For the time being, the tumor is gone but it could

always come back. At least for now, however, it is in remission. But Wendy is now in the position of having to take care of both her daughter, who is so very brave, and James, so very not.

Meanwhile James is trying his best but has suddenly become so old, so frail, no longer strong, no longer virile, just skin and bones, no muscle, but always ever so grateful to Wendy, so appreciative of her care, and so adoring of her. And Wendy is beside herself with the pain of not knowing what to do.

Confronting the Reality of Another's Limitations

In one of Wendy's journal entries to me, she writes: "I don't know if I even love him anymore – maybe I don't have enough love in me... Is there perhaps something wrong with me? I feel so sad – I feel this deep pain – it's just that I'm not sure I can keep doing this – I think, O my God, will I have to be caring for him, like this, from here on out?"

Later, Wendy laments: "James has been so transformed into an old man, shuffle feet, peeing all night long, partly deaf, slow mind, confused – his skin hangs slack on his face, he has no muscles at all – out of breath after a simple staircase – I am finding it hard to think of him as anything but my duty – not my lover or partner – he seems to have become another child – we barely touch each other anymore – I think because he is ashamed of how he looks and because I am so often seething with a kind of inner rage – I know I am

selfish and so I try to hide it, but of course what I feel then is – nothing – absolute deadness inside – I don't want to be his nurse-maid – I don't want to take care of him – and I don't want to have to be angry like this all the time and feeling so bad about myself!"

Later still, she writes: "I keep reminding myself, just row, Wendy, just row – meaning, just keep going and get through this – there is nothing to be resolved or talked about – it just is and I need to accept my duty and row – just keep rowing..."

Tormented and in despair, Wendy writes: "I wish I could find a way to open my heart up again – James is incredibly kind and grateful to me for everything – he is trying so hard to be helpful when he can and never complains and is so patient with me – he is exhausted and weak and miserable – while I am just grieving for our old love affair – the passionate sexy times we had together..."

A Tormenting Dilemma

One day James asks her: "Should I go?" And Wendy doesn't quite know how to answer. Does she say, "Well, let's give it a year and see what happens," which is what ultimately she does say, or does she suffer through it, resenting his baby-like, regressed behavior and having less time available for her daughter with the brain tumor and for her twins with their college

applications and for her writing (the realization of her life-long dream to get her writing really out there). In total heartbreak and pain, Wendy cries herself to sleep every night, ripping herself apart inside with the thought – “Maybe I just can’t be there for James in the way that he needs me to be – maybe I just don’t have it in me – maybe I’m just not strong enough...”

Wendy writes: “I’ve heard that the four sentences people who are dying need to say in order to get to the core of their relationships and be ready to say goodbye are – ‘Can you forgive me?’ ‘I forgive you.’ ‘Thank you.’ and ‘I love you.’”

Wendy comes to the States for her semi-annual meeting with me. It is a powerful session and there are many tears. But, later, she writes that one of the most healing things for her was my telling her that I thought she was doing the best that she possibly could. She goes on to write: “Funny, just that one little sentence – but it really helped to calm me inside and to make me feel less wracked with guilt and shame.”

Some time after her return to Paris, I receive the following: “Since our session, I have been writing and I feel so much better about everything – I feel like this whole experience with James and Elise was a huge tumultuous way of teaching me to remember mortality and fragility at the core – we are just little specks – that knowledge can be seen as both a terrifying nihilistic

nothingness and also this amazing miraculous moment – one can look at it either way – and both are right – we are just tiny bits in the vast infinite emptiness – or amazing that these tiny bits have this one incredible miracle moment of consciousness.”

The Inevitability of Disappointment and Heartbreak

Wendy continues: “I can go from one extreme to another in a matter of moments – maybe the Buddhist training of mindfulness is just that, trying to train us to stay focused on the miracle of now, instead of collapsing into disappointment that life is so meaningless...”

And in another communication, Wendy writes: “I have been thinking a lot about the Buddhist idea of disappointment – that ultimately we will all be disappointed by others, betrayed by others, it is part of the human condition, it is an integral part of relationship – sort of the fundamental core – accepting that disappointment...and accepting that we ourselves will be a disappointment to others – and to ourselves. A friend of mine, only half jokingly, once told me ‘Life is filled with disappointment – and all the rest is commentary.’”

Confronting the Reality of One’s Own Limitations

In essence, Wendy is running up against the limits of her own capability.

Hers is a poignant and touching story about encountering your own limits / your own limitations – and grieving them. Not hating yourself for having failed, but evolving ultimately to a place of humble acceptance that you have done the best, truly, that you could, under the circumstances. We’re not talking about being lazy or not trying very hard or giving up; we’re talking about when you try so hard and work so long at something and, even so, you just can’t quite pull it off. That’s what we’re talking about here. That’s what humble acceptance is all about – when you come finally to a place of accepting the reality of your own, very real limitations – knowing that you are truly doing the very best that you can – and that this very best, even if not all that you would have wanted it to be, is indeed “good enough.”

Importantly, as Wendy has become more accepting of her limitations and less relentless in her pursuit of perfection with respect to James, her children, her writing, her job, she has become more humbly compassionate in relation to herself and, even if sometimes impatient or annoyed, better able to be a loving partner to James at the same time that she is better able to channel laser-focused energy into her writing.

Clinical Vignette: A Haunting Chronicle of Horrific Loss

My last vignette is the published story of a woman, Sonali Deraniyagala, who was visiting Sri Lanka with her family in 2004 when the wave hit, the

tsunami that ultimately claimed the lives of some 230,000 people. Sonali's 2013 book, *Wave* (deservedly a *New York Times* bestseller), is piercingly honest, gripping, vulnerable, and raw. It is a haunting chronicle of love, horrific loss, unbearable grief, and (after many years of first avoidance and then gradual revisiting of the trauma and, bit by bit, daring to relive and, even, embrace it) slow, gradual healing and redemption.

Sonali, her husband, their two boys, and her parents were vacationing at a hotel on the beach in Sri Lanka when the wave, more than 30 feet high, suddenly charges inland at a speed of 25 miles per hour and for more than 2 miles before it just as suddenly retreats and heads back out to sea.

It is Sonali who, from her hotel window, first sees the wave approaching. It is she who mobilizes her husband, grabs their boys, and rushes them all out of their room and down the hall. Her parents' room is right next to theirs but, in a "splintered second," she makes the decision not to stop in order "to bang on their door or shout out to warn them." All she can think is "We must keep running." Later she learns that her parents have perished.

And then Sonali, her husband, and their boys are being rushed to higher ground in a jeep driven by somebody who works at the hotel. But the wave soon overtakes and engulfs them and everyone is suddenly being tossed

about relentlessly and propelled forward in the filthy, swirling water. At some point, disoriented and traumatized, she becomes vaguely aware of the fact that she has become separated from her husband and both boys and, later, she learns that they too have perished.

Miraculously Sonali herself survives by reaching up, at the last minute, to grab hold of an overhanging tree branch to which she clings for dear life, until she is rescued by a local.

Searing Guilt and Unrelenting Self-Recrimination

During the days, weeks, months, and years that follow, Sonali struggles to manage the searing guilt and unrelenting self-recrimination that haunt her night and day – that as she was reaching up to grab ahold of the tree branch that would save her life, her family was being swept away. She torments herself with the knowing that “After the water disappeared, I didn’t even look for them – I abandoned them, and that sickens me...I was in a stupor, true, I was shaking and shivering and coughing up blood but still I berate myself for not scouring the earth for them – my screams should have had no end – I loathe myself for not howling endlessly.”

And later still Sonali finds herself wondering if perhaps she was a “mass murderer” in a previous life. “I balk at the failure that I am – quite separate, this, from the more obvious agony of missing them.”

The remainder of the book is a chronicling of her torturous efforts, over the course of the next nine years, to manage the agony of her despair and the desolation of her spirit without her boys, without her husband, without her parents, wracked with obliterating shame and excoriating guilt, knowing that she had made choices that enabled her to live but contributed to the deaths of those she loved most dearly.

At first, Sonali refuses to remember and instead engages in all sorts of impulsive and destructive behaviors, contemplating suicide, drinking to oblivion, driving recklessly, berating herself mercilessly, stalking the people who move into her childhood home. She does her best to keep herself as numb and dissociated as possible, desperately intent upon not remembering, not going back, not revisiting.

Daring to Remember the Horror of It All

But over the course of the years, Sonali finds herself beginning to remember not just the horrific details of the trauma itself but also the bittersweet details of the life she had once shared with her family. And as, bit by bit, she dares to remember, she is startled to discover that her life begins to “cohere a little.” When she pretends not to remember, she loses track of herself, becomes “hazy” about her identity, as if she were somebody else or in a “witness protection program.”

But as Sonali comes increasingly to a place of remembrance, she writes: “I have learned that I can only recover myself when I keep [my family] near. If I distance myself from them...I am fractured. I am left feeling I’ve blundered into a stranger’s life.” But when she allows her mind slowly to “unclench” and “allow in” glimpses of the beauty that used to be, she rediscovers a “brightness” and an aliveness in herself that she had feared were gone forever.

Redemption and Absolution

What shines through, in Sonali’s unflinchingly honest chronicling of her journey back, is the courage it takes for her, over time, to begin to dare to face her haunting guilt and her intense shame – to relive, moment by moment, the horror of it all – ultimately realizing that, under the circumstances, she had indeed done the best that she could. And, by the end of the book, the reader as well, with compassion and without judgment, understands that truly Sonali had done the very best that she possibly could.

At the end of the day, Sonali’s journey back is a story about redemption, absolution, forgiveness, acceptance, and humility.

In the acknowledgements, Sonali offers heartfelt thanks to Dr. Mark Epstein, the “extraordinary therapist” with whom she felt “safe enough” that she could try to “grasp the unfathomable” and “dare to remember,” ultimately

arriving at a place of sober acceptance and inner calm.

Conclusion

In conclusion: I have come to realize that being able to experience the self as good enough was actually a story about not only relenting, grieving, and accepting but also forgiving. “Learn to forgive yourself again and again and again and again.” The healing power of forgiveness – of others and of the self.

In the words of the theologian Lewis B. Smedes, “To forgive is to set a prisoner free and discover that the prisoner was you” (1984).

Chapter 3 – Acceptance, Forgiveness, and the Capacity to Relent

“When a deep injury is done us, we never recover until we forgive.”

– Alan Paton (1953)

Elsewhere I have written that relentless hope is a defense to which the patient clings in order not to have to feel the pain of her disappointment in the object, the hope a defense ultimately against grieving (Stark 1994a, 1994b, 1999, 2015). The patient’s refusal to deal with the pain of her grief about the object, be it the infantile, a contemporary, or the transference object, fuels the relentlessness with which she pursues it, both the relentlessness of her hope that she might yet be able to make the object over into what she would want it to be and the relentlessness of the outrage she experiences in those moments of dawning recognition that, despite her best efforts and her most fervent desire, she might never be able to make that actually happen.

The Need to Possess and Control

But even more fundamentally, what fuels the intensity of the patient’s pursuit is the fact of the object’s existence as separate from hers, as outside the sphere of her omnipotence, and as therefore unable to be either

possessed or controlled. In truth, it is this very immutability of the object, the fact that the object cannot be forced to change, that provides the propulsive fuel for the patient's relentless pursuit.

Paradoxically, such patients are never relentless in their pursuit of good objects. Rather, their relentless pursuit is of bad objects. In other words, it is never enough that the patient simply find a new good object to compensate for how bad the old infantile object had been. Rather, the compelling need becomes first to create or, more accurately, to re-create the old bad object – the comfort of the familial and therefore familiar (Mitchell 1988) – and then to pressure, manipulate, prod, force, coerce this old bad object to change.

My contention is that the patient's relentless pursuit of the bad object has both masochistic and sadistic components. The patient's relentless hope, which fuels her masochism, is the stance to which she desperately clings in order to avoid confronting certain intolerably painful realities about the object's limitations, separateness, and immutability, and her relentless outrage, which fuels her sadism, is the stance to which she resorts in those moments of dawning recognition that the object is separate, has its own center of initiative, and cannot be forced to be something it isn't.

The Masochistic Defense of Relentless Hope

More specifically, masochism is a story about the patient's hope, her

relentless hope, mobilized in the face of the intolerable pain she would experience were she to let herself know the truth about the object's limitations, separateness, and immutability, her hoping against hope that perhaps someday, somehow, someday, were she to be but good enough, try hard enough, be persuasive enough, persist long enough, suffer deeply enough, or be *masochistic* enough, she might yet be able to extract from the object (sometimes the parent herself, sometimes a stand-in for the parent) the recognition and love denied her as a child – in other words, that she might yet be able to compel the immutable object to relent.

And so even in the face of incontrovertible evidence to the contrary, the patient pursues the object of her desire with a vengeance, the intensity of this pursuit fueled by her conviction that the object could give it (were the object but willing), should give it (because this is the patient's due), and would give it (were she, the patient, but able to get it right).

Please note that the patient's investment is not so much in the suffering per se as it is in her passionate hope that, perhaps, this time....

The Sadistic Defense of Relentless Outrage

Sadism is then the relentless patient's reaction to the loss of hope she experiences in those moments of dawning recognition that she is not, after all, going to get what she had so desperately wanted and felt she needed in order

to go on, in those moments of anguished heartbreak when she is confronted head-on with the inescapable reality of the object's separateness and refusal to relent.

Instead of confronting the pain of her disappointment, grieving the loss of her illusions, and relinquishing her determined pursuit, the relentless patient does something else. With the dawning recognition that the object cannot be possessed and controlled and cannot be made over into what she would want it to be, the patient responds with the sadistic unleashing of a torrent of abuse directed either toward herself for having failed to get what she had so desperately wanted or toward the disappointing object for having failed to provide it. She may alternate between enraged protests at her own inadequacy and scathing reproaches against the object for having thwarted her desire.

Sadism, therefore, is the relentless patient's reaction to the loss of hope.

The Sadomasochistic Cycle

The sadomasochistic cycle is then repeated once the seductive object throws the patient a few crumbs. The sadomasochist, ever hungry for such morsels, will become once again hooked and revert to her original stance of suffering, sacrifice, and surrender in a repeat attempt to get what she so desperately wants and feels she must have.

Co-Creation of Therapeutic Impasses

Over time, I have come increasingly to appreciate that when a patient is in the throes of her relentless pursuit of the therapist, it is usually a story about not only the patient but also the therapist, that is, it is a mutual enactment. The patient's contribution has to do, admittedly, with her refusal to take no for an answer; but the therapist may also be contributing by way of her unwitting seductiveness, whereby she initially offers, whether explicitly or implicitly, verbally or nonverbally, the enticing promise of a yes, only later to say no. In other words, the patient's relentless pursuit of the therapist is usually co-created, with contributions from both patient and therapist.

The Sadomasochistic Dance

The sadomasochistic dance that emerges at the intimate edge (Ehrenberg 1992) of relentless relatedness between patient and therapist will be tormenting for both and may last for weeks, months, years, at least until somebody does something. It is the therapist's responsibility to do that something. If there is to be resolution of their relentlessly stalemated crunch situation (Russell 1980), then the therapist must be able to hold herself accountable for her contribution to the gridlock. In other words, she herself must have the capacity to relent and to let go on behalf of a patient who truly does not know how. After all, how can the therapist expect the patient to relent if she herself cannot?

In other words, the therapist must have capacity where the patient has need; the therapist must have the capacity to let go where the patient has the need to hold on.

It's about accountability and the capacity to relent. If the therapist has the capacity to hold herself accountable and to relent, then it will be so much easier, ultimately, for the patient herself to relent, to admit, to acknowledge, to take ownership, to take responsibility, to back off, to relinquish, to let go.

The Therapist's Refusal to Relent

But in tragic situations where the therapist refuses to relent, either because she has the capacity to relent but won't or because she lacks this capacity to begin with, if the therapy is ever to move beyond this stalemate, then, unfortunately, it will fall to the patient to be the one who has to relent first. Heartbreaking. This is not the way it should be but often it is because many therapists have great difficulty holding themselves accountable for their unwitting enactments. Think about it. In your time, what have you, as a therapist, had the wisdom, courage, and integrity to acknowledge, certainly to yourself and possibly to the patient as well?

To repeat: When the therapist lacks the capacity to relent, then, sadly, it may well fall to the patient to be the one big enough to relent. And the patient will then have to confront and grieve, in addition to whatever other

disappointments she might have, the devastatingly painful reality that her therapist does not have the capacity to hold herself accountable for her own enactments.

The clinical vignette that follows is about a therapist whose refusal to recognize her contribution to a gridlocked crunch situation between patient and therapist has had disastrously tragic consequences for the patient.

Clinical Vignette: The Therapist's Refusal to Hold Herself Accountable

I present the case of Dr. Mary Nelson, a PhD psychologist whom I have known for a long time. Many years ago, Mary came to me for a one-shot consultation, at which time she presented with many borderline features and a dreadful early-on history of multiple traumas. But most striking was Mary's desperate desire to get better.

Twelve years later Mary returned to me for another consultation, reporting that in the interim she had been in treatment with a superb clinician, Dr. Rose, with whom she had worked intensively for ten years and whom she still saw intermittently. They had done extraordinarily good work. They were obviously an excellent match and deeply committed to their work together. Over the course of the years, Mary had gained considerable insight; had learned to tolerate intense affect and internal conflict; and, over all, had developed a much more solid sense of herself and her own capacity.

Paradise Lost and Never Refound

But Mary reported that her world had been shattered when, eight and a half years into their ten-year treatment, Dr. Rose had announced that in six months she would be returning to school for several years of postgraduate education, a time-consuming proposition that would require of her that she cut back on their sessions from twice to once a week and, more generally, be less available to Mary between sessions.

Dr. Rose and Mary did the best they could to plan for the disruption to their work. But once Dr. Rose's rigorous training program began and she found herself consumed with her many new clinical responsibilities, Mary began to come undone. In her desperation, she frantically reached out to her therapist for help, just as she would have done in the past when in crisis. Dr. Rose attempted as best she could to respond to Mary's pleas for help but eventually, as Mary's demands continued to escalate, Dr. Rose, simply unable to devote either the time or the energy, became more and more defensive, angry, and withholding.

Dr. Rose told Mary that she would need to face the reality that Dr. Rose could simply no longer be available to her in the ways that she had once been; she suggested that Mary's relentlessness spoke to Mary's refusal to confront the reality of this and that Mary needed to let go of her unrealistic expectations.

But Mary, unable to contain either her devastation or her outrage, had had ten hospitalizations over the course of the next year for alcohol and drug abuse and, sometimes, suicidality, amazingly enough continuing, all the while, her private practice of psychotherapy, admittedly with frequent interruptions.

Desperation, Confusion, and Rage

It was in this context and with the blessing of her therapist that about six months ago Mary, broken, frantic, enraged, confused, and desperate, returned to me after twelve years for a consultation, which has become an extended evaluation. Although Mary is in a rage at Dr. Rose and in excruciating pain, it has been obvious to both Mary and me how much she has grown as a result of the hard work she and Dr. Rose did together.

In our work, it has become clear over time that Mary's outrage at this point has to do not so much with the fact of Dr. Rose's decreased availability as with Dr. Rose's reluctance to recognize both the extent to which she has shut down in the face of Mary's unrelenting rage and the devastating impact on Mary of Dr. Rose's refusal to acknowledge this. Whereas Dr. Rose's interpretive efforts are directed primarily to Mary's relentlessness, Mary's enraged protest is that what she most wants is for Dr. Rose to acknowledge that she is no longer lovingly available in the way that she had once been.

Heartbreak and Despair

In Mary's journal, which she kept during her time with Dr. Rose, she wrote of her heartbreak as follows:

I remember your telling me that it would be safe to deliver to you what I feared the most.

I remember your saying over and over again so many times, "I'm not going anywhere; I am here to see you through all of this."

You said I would never again have to cry alone.

You made the space between us so safe that I could deliver to you what so badly needed to be said and experienced.

You wrote me notes that I could carry with me if I forgot that you were there.

You said I could call, especially when the pain got to be too much.

But then came all the changes. I lost my balance and fell.

All of a sudden I couldn't hold on to you anymore. And the depression and the terror went so deep that I kept ending up in the hospital.

People didn't understand why I couldn't just leave my therapy. "Simple," they said. "If it causes pain and it isn't working, then leave!"

But I couldn't forget how it had once worked. I couldn't forget about all the time, the energy, and the effort that had gone into our therapy.

But now I can't find you anymore. I don't know who you are or where you went.

I have pulled inside and don't reach out to you anymore. And you don't lean forward in your seat to listen to me anymore.

I do cry alone – I cry because of all the pain. You promised that you would always be there for me, but you aren't.

I am so worn out and panicked that you, as I knew you, are never coming back.

I tear apart inside trying to get back to the place where we once were. I keep trying to find you but you are not there. I cry out – but you no longer listen.

I am broken and my heart is shattered.

Are you gone from me? Trust me, this is not something casual – this is

something so serious. It is the core of the work that needs to be done – but you are nowhere to be found.

Again, it is not so much Dr. Rose's withdrawal that has shattered Mary's heart but rather Dr. Rose's refusal to acknowledge that withdrawal.

The Power to Harm and the Power to Heal

I believe, deeply, that ultimately it is the therapist who must be held accountable for what transpires at the intimate edge between patient and therapist. Although, as we have seen, both players have their parts and both contribute to the interactive dynamic that gets unwittingly played out between them, it is the therapist who, in the final analysis, is responsible for what happens. Whereas the patient may have the defensive need to deny, it is crucial that the therapist have the adaptive capacity to admit.

After all, it is the therapist who, by allowing herself to be cast in the role of the original parent, has the power both to break the patient's heart and to heal it.

Once the therapist has been able to recognize and to acknowledge, certainly to herself, quite possibly to the patient as well, her contribution to what has been mutually enacted between them, patient and therapist can go on to look at the patient's contribution.

As Patient and Therapist Grieve Together...

Patient and therapist can then wend their way out of what has become a stalemated situation by grieving together the reality that, much as both would have wished that it could have been otherwise, the therapist will never be able, entirely, to make up the difference to the patient or be the ideal parent both would have wished she could have been.

Then – and only then – can the patient go on to grieve the inescapable reality that no one will ever be for her the good parent she should have had early on and for whom she has spent a lifetime searching. In the process, she will be relenting.

In essence, the patient's relentless hope and relentless outrage will become transformed into the healthy, adult capacity to accept the sobering reality that one cannot make one's objects change but that one can and must take ownership of, and responsibility for, all that one can change within oneself. The Serenity Prayer speaks directly to this issue: "God grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference"

Clinical Vignette: The Struggle to Accept and Forgive

I present now a case vignette that I wrote in 2012 and have entitled

“The Struggle to Accept and Forgive.” It is actually a story about me and it is a story about acceptance and forgiveness. It took me years to understand that the capacity to relent is ultimately a story about acceptance and forgiveness.

It is only somewhat with tongue in cheek that I offer the following, rather sober reflection: It’s because of the way my mother loved me that I feel I need to work as hard as I do, but it’s because of the way my father loved me that I can.

So what follows is a story about my mom, dead now for eleven years (she would have been 104 this year). In 2011 my dad died at 98; he died of a broken heart, from missing my mom so much.

On some level, I don’t think my mother ever really wanted to be a mother. It took years and years for Susan (my sister), Doug (my brother), and me to put our finger on it but, ultimately, the three of us agreed that it was probably Mom’s reluctance to be a mother that made her so difficult. It was not so much that she did bad stuff as that she didn’t do enough good stuff.

Mom had started out in a promising career. An undergrad at UCLA, she had gone on to earn a master’s degree from Columbia and had then worked, for a number of years, with the anthropologist Margaret Mead. But in her late 30s, after she had given birth to the three of us kids (we’re all two years apart and I’m the middle child), Mom decided by her own choice (everything was

always by her own choice) to shift to a less demanding job and to work only part-time.

Mom performed her motherly duties but we sensed that there was no real pleasure for her in taking care of us. She didn't like cooking, she didn't like doing the laundry, she didn't like making the beds, she didn't like housecleaning, she didn't like picking us up after school. She did these things but she didn't like doing them. She didn't necessarily say that she didn't like doing them, but we knew that she didn't. We did everything we could to help her out but that still left a lot for Mom to do.

Mom was especially reluctant to take care of us when we were sick, so we soon learned not to get sick. I learned that lesson so well that I have never missed a day of work or school because of illness, except when I was seven and had chickenpox. Susan and Doug have held themselves to that same high standard. We did not want to burden Mom. Or, perhaps more accurately, we did not want to run the risk of being sick and feeling the pain of having Mom be only begrudgingly available.

Meanwhile, Dad, with whom I had always had a very special connection, was gently, kindly, and lovingly present but he was not a very dynamic presence in the household. He was either at work or, when not working, busy with his chess matches, his bridge tournaments, or his "contests." It was Mom

who assumed most of the childcare responsibilities, although she was also very involved in the community, the church, the school.

Somewhat surprisingly for us kids, Mom and Dad actually had a very sweet, tender, and loving relationship. Of course the three of us kids gave Dad (and his capacity to accommodate) the credit for that. But Mom and Dad had a pretty wonderful 65 years together including their daily “Happy Hour” before dinner (always half a glass of wine for each and their 65 years of Scrabble for which they kept a running tally – in the earlier years Mom the high scorer, in the later years Dad the high scorer – and ultimately, by the time Mom died, a tie) and always their hour of reading to each other before bed.

But back to my story. Meanwhile, and this was the killer, all the neighbors loved Mom, the mailman loved Mom, the cashiers at the bank loved Mom, everybody loved Mom. Particularly annoying for me was the fact that all my friends loved Mom. But that’s because they didn’t have her as their mom. She was, admittedly, a wonderfully interesting woman with a broad range of experience and interests and lots of fascinating stories that she was able to recount in a very engaging and often hysterically funny manner. And she was a good listener, remembering details about people’s lives and always interested in hearing more. People would confide in her, and she would offer them wise counsel. She was charming and gracious all right, but mostly to other people. On the home front, well, not so much. Susan, Doug, and I found

her to be a difficult woman.

Fast forward many decades: Susan, Doug, and I have all created reasonably satisfying lives for ourselves. We all have life partners (I've been with my sweet Gunnar for 33 years) but, sadly and tellingly, none of us ever wanted to have children.

During my 20s and 30s I spent years and years, in first therapy and then analysis, struggling, among other things, to make my peace with Mom's limitations as a mother. But even after all my years in treatment, Mom was still an enigma to me. Unanswered was the question: "Does Mom know that she is more generous to the neighbors than she is to us?" I just couldn't figure that one out.

I worked so hard in my therapy to grieve the reality of my mother's failures as a mother but I'm not entirely sure that, even after all those years, I ever really came to terms with the pain of my heartache about Mom and the pain of my loneliness in the face of her lack of warm-fuzzy availability. Nor, sadly, did I ever really get to a place of wanting to open my heart to her or of enjoying my time with her. Fortunately for me, I guess, I was also working on, and accomplishing, other things in my therapy but never did I really master the pain of the grief I felt about my mother's reluctance to be a mom.

Again fast forward to 14 years ago and a weekend during the summer of

1998, when there was a big family reunion at Ogy, my family's summer cottage on Keuka Lake, one of the Finger Lakes in western New York State. Mom was 90 at the time. Most of the extended family were staying at the cottage but Mom and Dad were staying at a small hotel close by, and Gunnar and I were staying at a bed and breakfast within minutes of the hotel.

Upon Gunnar's encouragement, bless his soul, Saturday evening he and I made a surprise visit to Mom and Dad at their hotel. I had already spent time at Ogy with Mom and Dad and everybody else during the day and into the evening on Friday and during the day on Saturday. But Gunnar wanted me to have some extra, special time with my parents. I didn't want that particularly, but my dear wise sweet Gunnar said he thought I should do it anyway. So I did. I almost always do what Gunnar says I should do.

Somewhat surprisingly, the visit, which lasted for hours, was wonderful. The four of us settled into a cozy parlor at the hotel and ended up having an absolutely fabulous time. We shared stories, reminisced, laughed, giggled, teased each another, talked about living, commiserated about dying; it was unusually intimate, delightfully enjoyable, and deeply healing. Afterwards, I held Gunnar close and thanked him from the bottom of my heart for having had the wisdom to know what I needed, and, perhaps, what Mom and Dad needed as well.

The next morning Gunnar and I got up. Our plan had been to head back to Boston. But Gunnar said he thought I should visit my mother again; this time it would be extra special because it would be just Mom and me (Dad was wrapping things up at Ogy). So Gunnar dropped me off at the hotel and headed on to Ogy to join Dad and the few remaining others.

When the owner of the hotel appeared at the door and I told her that I had come back to spend some more time with Mom, this kind-hearted woman almost wept for joy and whispered excitedly, “Oh, I know your mom will be so happy that you have come back to visit her again!” as she whisked me upstairs to my mom’s room at the top of the stairs.

The Moment of Relenting

I’m not sure if it happened when I stood in the doorway to my mom’s room or if it happened over the course of the next several hours of hanging out together and relaxing into each other, but what I do know is that as a result of our time together that wonderful day, something inside of me shifted and that, after years and years of holding it against my mother that she had had so little desire to be a mother, especially during my younger, more vulnerable years, I softened inside. I guess I finally relented.

I might never have had this opportunity but for Gunnar’s wise intervention. It really was he who got me to the threshold of her room. But

what happened next was something that I did, perhaps something that Mom and I did together. I stood in that doorway, looked at Mom's frail frame in the overstuffed chair by the window, beheld her absolute amazement and delight at seeing me there, felt that something inside of me yielding, and, much to my surprise, I rushed over to Mom and enveloped her frail body in my arms. I think we both wept as we held each other close.

Mom and I then proceeded to have one of the most precious, most intimate, most loving, most profound conversations that I have ever had with anyone. For reasons not entirely clear to me, I think I was able, for the first time in my life, to step back from my need for her to be my mother. I had always looked at her through the eyes of a young and vulnerable child wanting a good Mommy to take care of her. Not unreasonable, I suppose, although, with respect to Mom, it wasn't really her thing. As Karl Menninger once suggested, wanting the right things is reasonable but wanting the right things from the wrong people is unreasonable and a setup for heartbreak.

Relinquishing Infantile Need

But that warm, brilliantly sunny day in August of 1998, I let go of my need for my mom to be something she wasn't, and, after five decades of relentless pursuit, began to look at her through more loving and accepting and forgiving eyes. I had never really looked at her as the deeply wise and

wondrously complex, even if damaged in certain ways, woman that she was. I had always been filled with need and she was the object of my relentless desire. Sadly, I had spent a lifetime wanting her to be something she wasn't and would never be.

Present All Along, Just Waiting to Be Found

But that amazing, transformative day in August of 1998, when I stood in the doorway of that room, looked at my beautiful and vulnerable mother, seated in her overstuffed chair by the window, the summer breeze billowing through the lace curtains, I guess I kind of fell in love with her. To think that she had been there all along, waiting to be found and I had never guessed! I had been so caught up in needing her to be what I needed her to be that I had lost sight of who she really was. A little limited to be sure, certainly with respect to enjoying the mothering part, but an amazing woman nonetheless. And I felt so blessed to have found her. I had been so busy wanting and needing what wasn't that I had lost track of what was. Thank goodness she lived as long as she did so that I could have that opportunity!

Gunnar and Dad returned. Mom and Dad, their bags packed, were in the car, ready to leave. We had already exchanged wonderful hugs but as Dad was about to back out of the driveway, I impulsively ran over, leaned in through the window on my mother's side, and kissed her again, this time on the lips. It

was a very, very sweet and memorable moment. I had finally made my peace with who my mother was – I was finally accepting her – I had finally forgiven her. It had been years in the making, but the moment of relenting happened in a heartbeat. And it was so easy.

Acceptance, Forgiveness, and Appreciation

For 50 years I had been searching for my mom. But it was only once I had let go of my need for her to be a certain way that I was actually able to find her and accept her and forgive her and understand and appreciate what an amazing woman she was. And to think that I almost missed it because I was looking for something that wasn't.

Mom died three years later. But she and I savored every moment of time that we had together during those last precious four years.

Mom, I am so proud of you for having been, so unapologetically, who you were. Thank you for having had such faith in yourself, in us, in me, even during all those earlier, more difficult years. You steadfastly advised me to shoot for the moon, reminding me that if I missed, I would still land amid the stars.

Thank you, Mom, for taking the risks that you did and for giving me the space to take my own risks and to make my own choices. Thank you for giving

me the courage to dream. You gave me permission and encouragement to go for it, to seize the moment without fear, to make whatever mistakes I might need to make in order, ultimately, to find my truth. Thank you, Mom.

Because Mom had such courage and such wisdom, my own journey through life has been so much richer. Just knowing that Mom had already passed that way before me, paving the way by her courageous example, has made my own pilgrimage so much easier.

In Honor of My Mom

I am reminded of a beautiful poem by Will Allen Dromgoole called “The Bridge Builder” (Doud 1931). It is about an old man who is nearing the end of his life’s journey and a fair-haired youth following behind him. For the purposes of my story here, I am thinking of the old man as representing my mom and of the youth as representing me. Interestingly, Will Allen Dromgoole was a woman with a man’s name.

An old man going a lone highway
Came, at the evening cold and gray,
To a chasm vast and deep and wide.
Through which was flowing a sullen tide
The old man crossed in the twilight dim,
The sullen stream had no fear for him;
But he turned when safe on the other side
And built a bridge to span the tide.

“Old man,” said a fellow pilgrim near,

“You are wasting your strength with building here;
Your journey will end with the ending day,
You never again will pass this way;
You’ve crossed the chasm, deep and wide,
Why build you this bridge at evening tide?”

The builder lifted his old gray head;
“Good friend, in the path I have come,” he said,
“There followeth after me today
A youth whose feet must pass this way.
This chasm that has been as naught to me
To that fair-haired youth may a pitfall be;
He, too, must cross in the twilight dim;
Good friend, I am building this bridge for him.”

No Regrets

And by the time the end came and Mom looked back, I think she had few regrets. Over the years, when I, struggling as I was with this business of getting older and trying to create something meaningful along the way, when I would ask Mom if she would ever want to do it all over again, without fail Mom would say that she was so glad to be exactly where she was in her life, that she had no regrets, that were she to be able to do it all over again, she would have lived her life in the very same way, doing the very same things she had chosen to do the first time 'round.

But there came a time, several months before her death, when, knowing that she was nearing the end of her life’s journey, Mom told us that she was ready to die. Though her mind was as sharp as ever, her body had become old

and frail. She told us that she wanted to die but that she was afraid.

Finding the Strength Within to Overcome the Fear

Mom, who had never before been afraid, was now frightened. But somehow, bless her, over the course of those several months prior to her death, she managed to overcome her fear of dying, eventually finding within herself the faith and courage to face her death bravely. And so she ultimately welcomed death, once she had decided that the time was right to go, and she let herself die.

It has been said that “Courage is not the absence of fear but rather the judgment that something else is more important than fear...”

So in the end Mom was able to die as she had lived, with grace, dignity, and courage. I am so proud of her. When you’re able to do something that makes you afraid, that’s what constitutes real courage. And Mom had that.

For me, living has been so much less scary because of the way Mom was able to do it. And so, too, the thought of dying is now less scary for me because here as well, Mom showed us how it can be done in a way that preserves one’s dignity.

Saying Good-bye and Letting Go

And because Mom was able to let us know that she was going to let herself die, it gave all of us the opportunity to say good-bye to her, to thank her, and to give her permission to do what she wanted to do, which was to choose the time when she would actually die. She and I had a beautiful last visit before her death. Thank you, Mom, for being you and for giving me all that you did.

Oscar Wilde (1998) once said, “Children begin [life] by loving their parents; as they grow older, they judge them; and, [when they become older still], sometimes they forgive them.”

Yes, it took me years to understand that the capacity to relent is really a story about acceptance and forgiveness.

Chapter 4 – Introjective Identification: Taking on Another’s Experience as One’s Own

Clinical Vignette: Thomas’s Intense Yearning for One More Dance with His Father

I would like to start by presenting my work with Thomas, whom I saw for six years (from 2000 to 2006). By the time Thomas had terminated, he was no longer a dissociated, alienated, lonely, frightened “control freak” but a wonderfully engaged man who was living his life in an authentic and heartfelt way. Over the course of our years together, there was a very powerful dynamic operating between us but, at the time, I had no way to conceptualize what was actually taking place at our intimate edge because I had not, to that point, thought all that much about the somewhat elusive concept of introjective identification. Fortunately for Thomas and me, as is often true with respect to the therapeutic action, the thing that was taking place between us didn’t need to be understood at the time – it was simply enough that it was happening.

When first he came to me, Thomas was 32, a tall, lean, prematurely white-haired, handsome, bespectacled man, a college dropout who had nonetheless managed, by dint of his hard work, to become the owner of a fairly successful restaurant in Brookline. He presented with an agitated depression, reporting that his personal life had become a total “mess” because

of some really bad choices that he had made along the way. Thomas said he was desperate and needed my help in figuring out what he should do to straighten out his life.

Thomas was in a painfully empty marriage to Sandra, whom he had known since high school and with whom he had had two children, Bill and Dan; he was having a passionate affair with a wonderful woman named Molly, whom he considered his soul mate; he was dating Donna on the side because he was afraid to commit to Molly; he was still sexually involved from time to time with Doris, a former girl friend, because he couldn't bring himself to break things off with her; and he was the father of an illegitimate child by Jane, a one-night stand some years earlier that had produced a little girl named Autumn, whom Thomas had been allowed to see only a few times. Thomas, who loved music, was a songwriter, and played guitar, would say to me, with a slight, self-deprecating twinkle in his eye, "There should be songs written about having four women, but, I guess, who would be interested in such songs?"

Sometimes when Thomas was feeling especially bad about his "roaming eye," he would "practice not being attracted to other women," but he was never able to sustain his abstinence for long because he was so terrified of being alone. In the meantime, he lived by the rule: "Never get so close that it hurts when they leave."

Thomas was racked with guilt about everything. He “managed” his complicated life and what he called his “moral badness” and “sinful existence” by engaging in numbers of compulsive rituals and routines, by keeping himself always “at a remove” from too much involvement in life, and by maintaining “rigid robotic-like control” at all times. He was a “clean freak” who took four showers a day, carefully wiped down the engine in his car every week, and washed the outside of his house three times a year. Disciplined, structured, regimented, controlled – constructs he lived by. He loved orderedness, symmetry, balance, organization.

One of Thomas’s rituals centered around managing the delicate strings that he experienced as being attached to his back. He knew they weren’t really there, but their imagined presence, and their tendency to become entangled, troubled him deeply even so. Way in advance of his appointment time, Thomas would drive to my office, carefully get out of his car so that the strings wouldn’t get tangled, walk up my driveway using the same number of steps every time, come around to the back of my house, and enter the sun porch waiting room. Once inside, however, things would get a little more complicated. He had explained to me that it was easiest for him simply to remain standing quietly at attention inside the sun porch door instead of attempting to sit, because, in turning his body to take a seat, he might create an intolerably anxiety-provoking entangling of the strings.

Upon entering my office, he would carefully take a seat, knowing that, at the end of the hour, he would then need to “undo” that process by reversing the order of the actions that had brought him to that spot. Very carefully, therefore, Thomas would back out of my office, out of my waiting room, and down the driveway (the same number of steps down the driveway as steps up the driveway), and back into his car, without having messed up the strings. Thomas was a graceful man with a soft elegance, so he was able to manage all of this with such finesse that, unless you watched him closely, you might never notice.

Thomas’s goal in life, at that early stage in our treatment, was to keep his “path” as uncomplicated as possible, so that he would be able to avoid the potential for entanglement of the strings and, thereby, a shortening of his life. He recognized the irony in this, that he, whose life had been immeasurably complicated by virtue of the many “bad choices” he had made in his time, would be now so intent upon simplifying things. Thomas was deathly afraid of dying. And were the strings to become entangled and their length thereby shortened, well, the thought of this was terrifying for him and an all-too-poignant reminder of the finitude of life, the terrifying passage of time, and the inevitable end. He was tormented by thoughts of his own mortality and the knowing that nothing would last, nothing was permanent.

Thomas would tell me: “I have always thought that you should not think

about things that bother you. You should pretend the problems are not there. If you need to, you can have ‘scheduled unhappiness,’ whereby you designate a certain period of time to think about how unhappy you are. But then it is important to move on.”

In a desperate attempt to ease his pain, Thomas had been drinking alcoholically for over 14 years – although, shortly into his treatment, he stopped drinking on a dime when I happened to suggest, as a throwaway comment, that the drinking might be contributing to his agitation and his depression.

Not surprisingly, Thomas, for whom being in control was a top priority, wanted always to be in control of our sessions and of what he talked about, which was totally fine with me. And so the process between us unfolded gradually, organically, with Thomas always leading the way. In our sessions, he would share details about his life, speaking always in his “reporter mode”; between our sessions, he would often leave me messages on my voice mail in which he would report in with details about his week: “It’s Thomas, reporting in...” he would always say. Whether in session or between sessions, never the feelings, simply the facts. Again, all of this was just fine with me. Meanwhile, I was becoming very, very fond of this dear man whose vulnerable, tormented soul was so racked with guilt, sadness, and pain.

Thomas's father had been a very successful dentist, universally liked and admired, but he was a demanding father with very high standards. He was "very exacting," said Thomas, "good for the teeth but not for the son." His mother, an actuary, was a good woman, but with more "head" than "heart." Both parents were often absent, physically and emotionally. Early on in our work, Thomas said very little about them other than that he had loved them and they had loved him – and very little about his childhood.

There did come a time in our work, however, when Thomas began to talk about a dear childhood friend, Donny, with whom he had been very close and whom he had deeply trusted. He and Donny had lived next door to each other for many years and would play together for hours on end – make-believe games in which both would have superhuman powers and no vulnerabilities – and they would live forever.

Thomas had loved Donny dearly and was devastated when, with neither advance notice nor explanation, Donny and his family had suddenly left town when he and Donny were both nine. They had never even had a chance to say good-bye. Thomas, dissociated but clearly in pain, reported to me that he had never fully recovered from his grief about the loss of Donny, that some part of him had died the day he found out Donny was simply gone. As he recounted the details of their very special relationship and then Donny's sudden, incomprehensible, and devastating departure, Thomas shed no tears; rather,

it was I who began to tear up as Thomas spoke of his heartbreak.

Thomas witnessed my tears but made no mention of them, nor did I. But to the next session he came bearing a poem, which he had written over the course of the week in honor of his deep friendship with Donny. It was entitled *“Sometimes Sad, Forever –”*

When you and I were young,
We were forever,
We were in control,
And anything, everything was possible.

Our lives were as one,
Though not really.
I was you,
Though never quite.
Always, simply, wanting to be.

But then you slipped away.
Unscheduled. Forever.
Leaving me behind
With this sadness, this pain, this loneliness
that never lets up. Ever.

My dreams came crashing down around me
through a frightened void
shattered...
splinters lying, like an abandoned jigsaw puzzle
pieces missing – like my life.

I love you, Donny.
Forever and for always.
But you are gone from me.
Where did you go?

I am lost – and so desperately lonely without you.

Again and again, Thomas would ask rhetorically: “Why would you want to love someone if they’re going to leave you, anyway?”

Thomas had been an only child until he was 11, at which time his younger sister was born. He reported, “I was mean to her because I always thought that she was smarter than I was. She was a weird eater, 5’6” and 100 pounds. I didn’t like her that much, but I was afraid she might die on me because she was so skinny.”

His sister hadn’t died, but, when Thomas was 24, his father had – a horrific death, from cancer of the head of the pancreas.

Thomas reported: “I felt responsible for his death. When I was young, I had been my dad’s pride and joy. But, in high school, I began to live irresponsibly, drinking, drugging, lots of sex. I knew I was letting my dad down. I think he had wanted me to be a dentist, just like him. I was good with my hands and probably would have made a good dentist. But, in my late teens, I wasn’t caring much about stuff. I was just living on the edge – indulgently, destructively. And drinking a lot. I got a girl pregnant and then headed off to Europe for a little while. I was running away from everything.”

It was only after returning from Europe that Thomas had finally told his

father about his illegitimate daughter, Autumn. Father had been devastated and had said that he was not yet ready to meet her. This was the first, last, and only time they had spoken of Autumn but Thomas could not forgive himself for having given birth to this child out of wedlock in the first place and then for having burdened his father with the knowledge of it.

“My dad never asked me what was wrong with me or why my life was such a mess. We never talked about things like that. One day, however, just before my 24th birthday, totally unexpectedly, my dad invited me to have lunch with him, which wasn’t something he had ever before done. But we never had that lunch. He suddenly got very sick and was diagnosed with bad cancer. I have always wondered what he would have wanted to talk to me about. In my life, there is Part 1: the time before my dad got sick. Then there is Part 2: the time after my dad got sick.”

Later Thomas reported: “My dad was so disappointed in me. I know I let him down terribly. I think I broke his heart. I wasn’t the son he had wanted me to be. He had the cancer, but I think he died from a broken heart.”

As Thomas talked about his unresolved grief and tormenting heartache, his pain was palpable. As was often the case, when he would talk (he – ever the reporter) about his pain, his internal turmoil, his racking guilt, his sadness, his heartbreak, his anguish, his loneliness, it was I who would be

crying. And it happened a lot. Seeing my tears, Thomas would reach for the box of Kleenex beside his chair and hand it to me. I kept the box of Kleenex beside the patient chair and not my own because, with most of my patients, I myself didn't really need it. As I cried, Thomas would sit very still, patiently, gently, tenderly until I had composed myself and my tears had passed and then he would continue. Again, we never talked about my tears or what they might mean to him, or to me for that matter! It's just what we did together. He would speak of his heartbreak, and I would cry. And I loved it that he, ever attuned to my face, would offer me that Kleenex.

One particularly poignant moment was when Thomas was telling me about how he would regularly visit his father's gravesite even those many years later, where he would talk for hours and hours on end, softly, lovingly, apologetically, to his dad about his daughter Autumn and his regret and his guilt and his shame and all the things he wished he had been able to talk to his dad about "in the living years." Thomas would leave a special bouquet of carefully selected flowers for his dad because he knew how much his dad loved flowers and gardens, an interest they had in common.

As Thomas talked about one of the visits to his father's gravesite, I found myself crying so much – I was sobbing, actually – that Thomas had to stop talking for quite a while. Once my tears began to subside, Thomas asked me, gently, if it was OK for him to continue. I said, "I need another moment,

please.” So he sweetly waited. Again, Thomas and I never talked about my tears or his lack of them. It worked for us both.

Thomas was intrigued when, one day, I suggested to him that “grieving on your own is very inefficient but sharing the grief with someone else will make it so much more efficient.” He responded: “OK. You know, I had never really understood how you could complete something with someone who was already dead. Once you die, you’re dead. Like a rock. But maybe I could, you know, share the grief with you.”

Shortly thereafter, Thomas brought me another poem, which he had just written for his dad. It was entitled “*A Song to My Dad.*”

Dad, I’m writing you this letter, pretending you’ll get to know its contents
But, when I imagine your eyes, dried like raisins left lonely in their sockets
I feel the futility of it all, writing a letter that you will never read,
another exercise in self-indulgence
Just time wasted.

The last time I wrote to you, when I was 10
or was I in college?
I guess it doesn’t really matter.
The mandatory letters, meaningless anyway.

Now as I prepare to let you in
It is too late
Thirteen years or so – too late.

When we were told that you would be dying soon
when I climbed, shaking, the stairs to visit you in the hospital

my guts retching
I, always so good with words,
shrieking inside "Fuck you, God!!"
And there you lay, rotting,
on the Bullfinch Ward at the Mass General, a lobby for the almost dead.

I wonder, if you were to sit here with me
If I could make you know how much I love you
and how much I miss you – and how sorry I feel

I wonder, if I screamed it in your face,
As I have so many times at the Linwood Cemetery,
if you could ever know how much I ache for you

I need you to tell me you love me – in spite of it all
I need you to lie to me if necessary
That would be OK.

Then you could hug me like you used to when I was very small
and not yet a disappointment
and you weren't dead
or like you would have if I had let you
or like we did that time in the garden after we made it so beautiful
and full of life,
or as I should have when you became empty...
your life freshly ripped from its turncoat cocoon
by the bad cancer that would not relent

you were dead
you were dead too soon
you are dead forever

it feels very empty in here
I was told that after the mourning period, things would feel better
but my mourning period is lasting forever it seems
a just punishment.

I have fathered some children you would love
they would love you
they would want to spend some of their lives with you
you could hug them whenever you wanted
I could watch with pride, even as I was feeling envious longing
hoping no one would notice the difference

I've done a lot of disappointing since you left
I can't seem to shake it
I can't ever be you
I'm sorry
I didn't mean to kill you.

I love you,

Thomas

One day Thomas, who had always come on time for every single one of his sessions, in fact, sometimes up to 30 minutes early, came 5 minutes late, having been stuck in terrible traffic, and was totally distraught. To complicate matters, he was concerned that, in his haste, the strings attached to his back might have become entangled. Time, of course, every single moment, was so very precious to him. Ordinarily, I would not make up the time to a late patient but, with Thomas, I wanted to and so I told him that I would like to make up those five minutes to him at the end of our session. He was able to let me know that it meant the world to him, that I would have been willing to do this, and, I believe, it marked one of several turning points in the treatment. For reasons never entirely clear to either of us, after I gave him those five

minutes back, Thomas found himself becoming less and less concerned about the strings and their potential entanglement. In fact, he kind of forgot about the strings period, much as a young child, one day, simply lets go of his little blankie.

Over the course of our six years together, Thomas turned his life around. As he (and I) grieved the loss of Donny and, later, the loss of his dad, his heart began to heal and he became more engaged in life, more invested in life, less afraid, more grounded, less terrified of dying, more present, less frantic about the passage of time, more committed to living right and well and authentically, in the moment, and with passion.

Some time before the end of our work together, Thomas had divorced his wife, had stopped seeing the other girl friend, and had called things off with his sometime lover. Meanwhile, he and Molly were getting very serious and building a gorgeous house on a lake, the outside of which Thomas was not planning to wash! One very special day, as a thank you gift, Thomas proudly presented me with a beautiful photograph of his “family” at their new waterfront home, all of them happily relaxing on their deck overlooking the lake. The photograph included Molly, his two sons, Autumn (who, much to Thomas and Molly’s delight, now considered their home to be her home), and Thomas, grinning from ear to ear. Thomas said that it was because of our work together that he was now able to smile. I was incredibly touched. More

tears. Mine, of course. Throughout our time together, Thomas had never once shed a tear. But that was fine.

Thomas told me that one of the most comforting things I had ever told him was when I had shared with him the idea that if you were blessed enough to be in a mutually loving relationship, then inevitably either you would end up losing them (whether to death or to something else) or they would end up losing you. And that's just the way it was, an excruciatingly painful and sobering reality with which all of us must eventually make our peace. Thomas said that my sharing this "fundamental truth" with him had been clarifying and tremendously reassuring; it had helped him to feel less frightened, more grounded, and less alone.

And then it was time for us to say good-bye and we were ready for it, sad as it was for both of us. To one of our last sessions, Thomas brought his guitar and played for me Luther van Dross's heart-wrenching song entitled "Dance with My Father," about a young boy's aching to be able to dance, just one more time, with his dearly beloved but long-departed father. "I never dreamed that he would be gone from me / If I could steal one final glance, one final step, one final dance with him / I'd play a song that would never, ever end / 'Cause I'd love, love, love / To dance with my father again / Every night I fall asleep and this is all I ever dream."

I would like now to share with you what happened in the final moments of our last session. At the very end, when Thomas stood up to leave for the last time, no longer worried at all about any strings attached, I, with lots of tissues by my side, reached out my hand to take hold of his. He immediately reached for my hand, and I then placed my second hand around his. Then after only a moment's hesitation, he slowly raised his second hand to his face and, as I followed the movement of his arm, I could see that he was pointing to the tears that were welling up in his eyes and beginning to roll down his cheeks. He smiled sweetly at me through his tears and I, through my own, smiled back. A very special, tender moment that needed nothing more...

Thomas has stayed in touch over the years and periodically comes in for a touch-base session. He and Molly ended up going into business together and now run a chain of very successful, high-end restaurants. As Thomas with a twinkle in his eye recently observed, when first he had come to me, he had four women and one restaurant. Now he has one woman and four restaurants! We agreed that although you probably wouldn't want to be writing a song about having four women, you could probably write a pretty interesting one about having four restaurants!

Thomas and Molly gave birth to two lovely girls, Christie and Samantha, and their beautiful lakefront house is now home to these girls, Thomas's two sons, and Autumn. Thomas is supremely happy and tells me that his life is

now filled with moments of intense joy. He is aging gracefully. He is no longer afraid. His heart has healed and he has found internal peace. He no longer has the loneliness, no longer feels alienated, no longer dissociates, and is no longer a reporter. And sometimes he cries – when he feels like it. He still visits his dad’s gravesite, but he now feels that he carries his dad inside of him, that, at the end of the day, he did kind of end up being a lot like his dad. Ever humble, Thomas tells me, with quiet, heartfelt gratitude and pleasure, that he knows his dad would be proud of him. And I, personally, am quite sure that Thomas is right about that.

Introjective Identification vs. Projective Identification

Psychodynamic psychotherapy offers patients an opportunity, albeit belatedly, to process and integrate unmastered experience. If early-on trauma or abuse experienced by a child at the hands of his parent cannot be processed and integrated into healthy psychic structure, then the unmastered experience becomes structuralized in the mind of the developing child as internal badness (Stark 1994a, 1994b, 1999, 2015). The clinical challenge is then: Once traumatizing experience has become internally recorded as badness, how can it later be accessed in the treatment and detoxified?

I would like to highlight two ways that toxic experience (internal badness) can be processed, integrated, and detoxified: projective

identification and introjective identification.

The Patient as Initiator of the Therapeutic Action

Projective identification has two phases. The induction phase commences once the patient projects onto the therapist some aspect of the patient's experience that has been too toxic for the patient to process and integrate and then exerts pressure on the therapist to accept that projection, thereby inducing the therapist into the patient's enactment.

The resolution phase is ushered in once the therapist steps back from her participation in what has become a mutual enactment and brings to bear her own more evolved capacity to process and integrate on behalf of the patient, such that what is then re-internalized by the patient can be more easily assimilated into healthy psychic structure.

And, if all goes well, this dynamic will happen repeatedly, the net result of which will be gradual detoxification of the patient's internal toxicity.

The Therapist's More Evolved Capacity

Sometimes it is the therapist alone who does the processing and integrating on behalf of a patient who truly does not know how, and sometimes it will be patient and therapist working together at their intimate

edge, with shared mind and shared heart, who do the processing and integrating – the detoxification – of the patient’s toxic psychic contents.

The Poorly Understood Concept of Introjective Identification

Especially in contemporary relational theory, projective identification is a critically important aspect of the therapeutic action. But let me now speak to the rather poorly understood, and almost completely neglected, topic of introjective identification, an intriguing construct that has been variously and confusingly described in the psychodynamic literature as involving sometimes taking in and identifying with some admired aspect of the object (Freud 1923) and sometimes taking in and identifying with the bad object (Klein 1964).

The Therapist as Initiator of the Therapeutic Action

I would like to propose, however, that we use the concept to describe what happens not when the patient initiates the therapeutic action by exerting pressure on the therapist to take on as the therapist’s own some aspect of the patient’s unmastered experience, as happens with projective identification, but rather when the therapist initiates the therapeutic action by voluntarily entering into the patient’s internal world and taking on, as the therapist’s own, some aspect of the patient’s unmastered experience.

With introjective identification, here, too, sometimes it will be the therapist alone who does the processing and integrating on behalf of a patient who truly does not know how, and sometimes it will be patient and therapist working together at their intimate edge, with shared mind and shared heart, who do the processing and integrating – the detoxification – of the patient’s toxic psychic contents.

In both instances, the therapist will be lending aspects of her own capacity to a processing and integrating of some aspect of the patient’s experience that is overwhelming for the patient, but with projective identification it will be the patient who initiates the therapeutic action, whereas with introjective identification it will be the therapist who initiates it.

An Ongoing Relational Dynamic at the Intimate Edge

I believe that introjective identification is a relational dynamic that takes place continuously at the intimate edge of authentic engagement between patient and therapist and most certainly took place in my work with Thomas, especially with respect to his profoundly overwhelming grief and the tears he could not shed.

Introjective Identification in the Infant-Mother Relationship

Introjective identification takes place in not only the patient-therapist relationship but also the infant-mother relationship. Certainly a good mother who is attuned to her infant's moment-by-moment experience will use introjective identification as a matter of course. For example, an authentically engaged mother, sensing her infant's distress, will enter into the infant's dysregulated affective state and take it on as her own, lending aspects of her more evolved capacity to a processing and integrating of her child's unmastered experience. The mother will do this intuitively and repeatedly, the net result of which will be dilution and modulation of her child's experience of distress and eventual development of the child's capacity to manage overwhelming affect on his own. As this process continues, the child's need for external regulation of the self will become transformed over time into the capacity to be internally self-regulating.

Conclusion

In closing: I return now to Thomas and his heartbreak.

Empathic Attunement vs. Authentic Engagement

But first a point of clarification with respect to the processing and integrating of unresolved grief: I believe that there is an important clinical distinction to be made between *empathic attunement* in which the therapist decenters from her own experience, joins alongside the patient, and takes on

the patient's experience, but only *as if* it were her own (it never actually becomes her own) and *authentic engagement* in which the therapist allows the patient's experience to enter into her and takes it on *as her own*.

Being Alone in the Presence of Another vs. Sharing the Experience with Another

In the first instance, of empathic attunement, the therapist will resonate with and validate the patient's experience of grief, but it will be the patient who must do the grieving as he, on his own, confronts the painful reality of his devastating heartbreak. Borrowing from Winnicott (1965), the patient will be "alone (with his grief) in the presence of (a caring other)" but alone he will be.

In the second instance of authentic engagement, the patient will be not "alone in the presence of another" but "sharing the experience with another" who is willing and able with shared mind and shared heart to feel, along with the patient, the pain of the patient's devastating heartbreak, such that the patient's experience of grieving need no longer be such a lonely one.

From My Tears to His

In my work with Thomas at our intimate edge, I myself by way of introjective identification experienced Thomas's incredible pain and shed his tears until he himself was eventually able to bear the incredible pain – and shed his own tears.

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